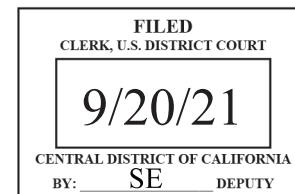


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27 *Attorneys for Relators and Plaintiff-Relator*



20 IN THE UNITED STATES DISTRICT COURT

21 FOR THE CENTRAL DISTRICT OF CALIFORNIA

22 [UNDER SEAL],  
23 Plaintiffs,

24 v.

25 [UNDER SEAL],  
26 Defendants.

CASE NO. CV 18-08311-ODW(AS)

PART 4 OF 13  
(EXHIBITS 38 – 42)

FOURTH AMENDED COMPLAINT

28 [FILED IN CAMERA AND UNDER SEAL  
PURSUANT TO 31 U.S.C. § 3730(b)(2)]

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25 *Attorneys for Relators and Plaintiff-Relator*

26 **IN THE UNITED STATES DISTRICT COURT**  
27  
**FOR THE CENTRAL DISTRICT OF CALIFORNIA**

28  
**UNITED STATES OF AMERICA *ex*  
*rel.* IONM LLC, a Delaware corporation  
and *ex rel.* JUSTIN  
CHEONGSIATMOY, M.D.;  
STATE OF CALIFORNIA *ex rel.*  
IONM LLC, a Delaware corporation and  
*ex rel.* JUSTIN CHEONGSIATMOY,**

**CASE NO. CV 18-08311-ODW(AS)**

**PART 4 OF 13  
(EXHIBITS 38 – 42)**

**FOURTH AMENDED COMPLAINT**

FOURTH AMENDED COMPLAINT EXHIBITS PART 4 OF 13 (38-42)  
CASE NO. CV 18-08311-ODW(AS)

1 **M.D; and LOS ANGELES COUNTY *ex* rel. IONM LLC**, a Delaware corporation;  
2 and *ex rel.* **JUSTIN CHEONGSIATMOY, M.D., and**  
3 **JUSTIN CHEONGSIATMOY, M.D., in**  
4 his individual capacity

5 Plaintiffs,

6 v.

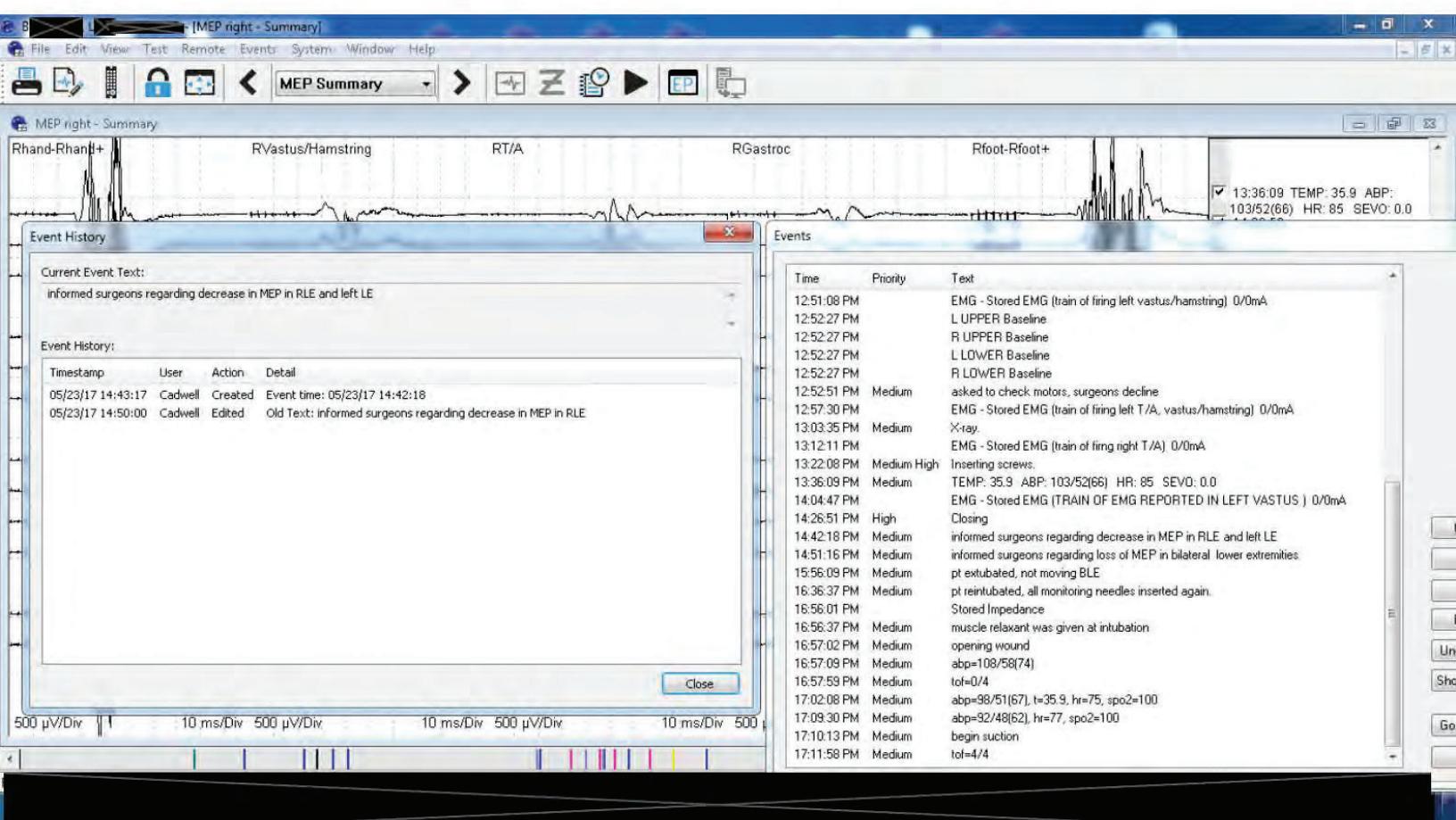
7 **UNIVERSITY OF SOUTHERN**  
8 **CALIFORNIA**, a California corporation;  
9 and

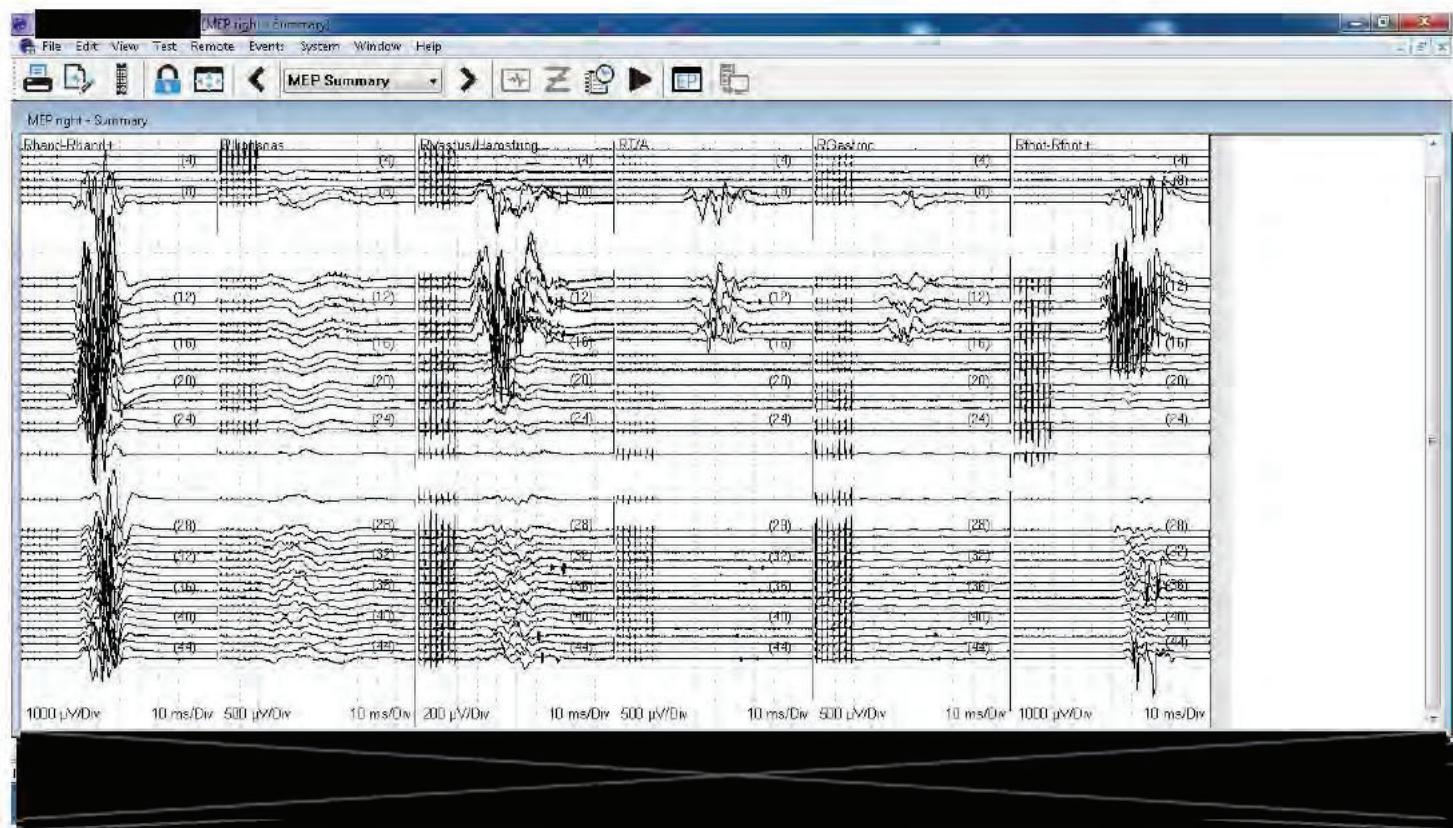
10 **USC CARE MEDICAL GROUP, INC.,**  
11 a California corporation,

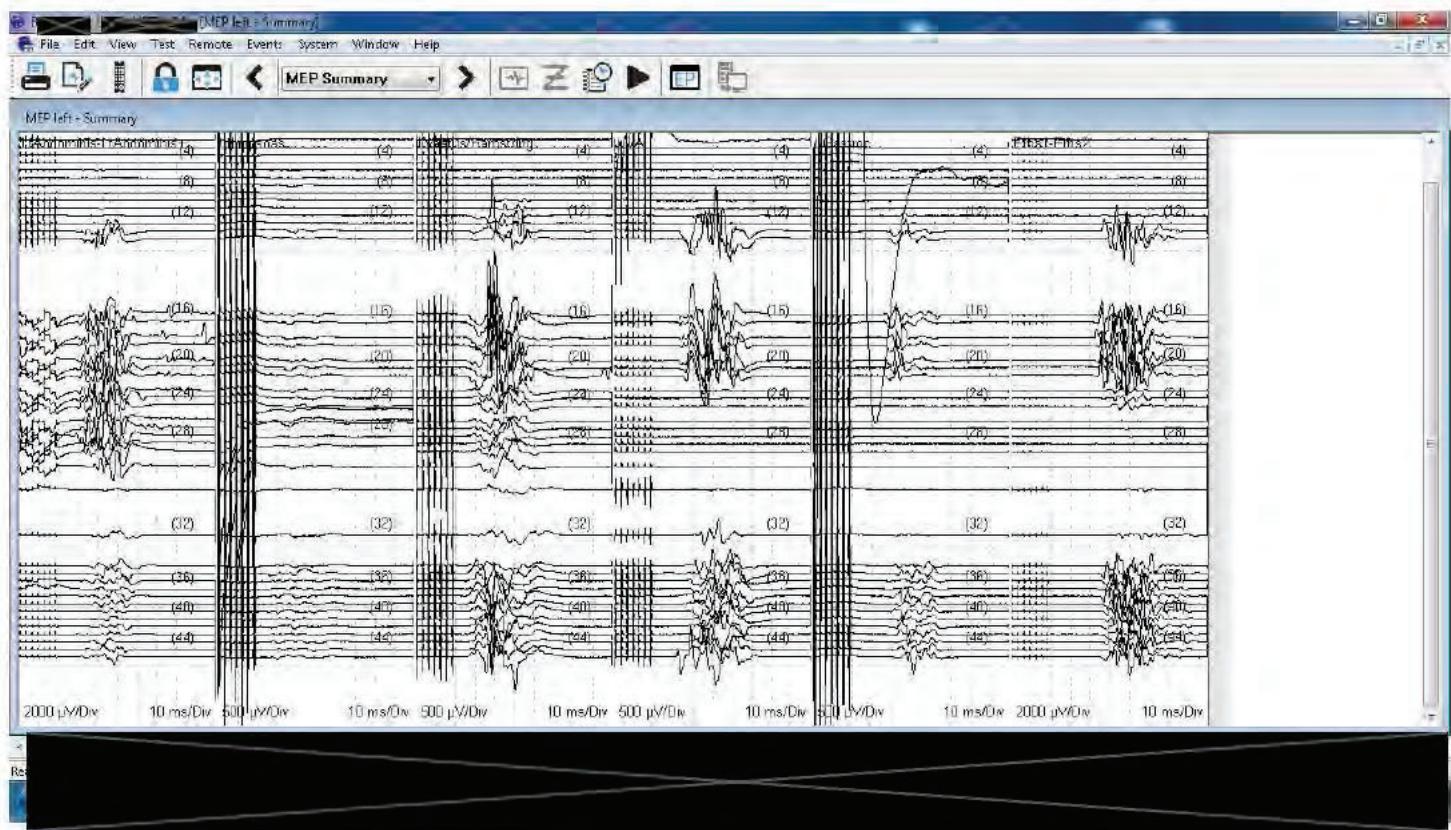
12 Defendants.

13  
14  
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16  
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19 **[FILED IN CAMERA AND UNDER SEAL**  
20 **PURSUANT TO 31 U.S.C. § 3730(b)(2)]**

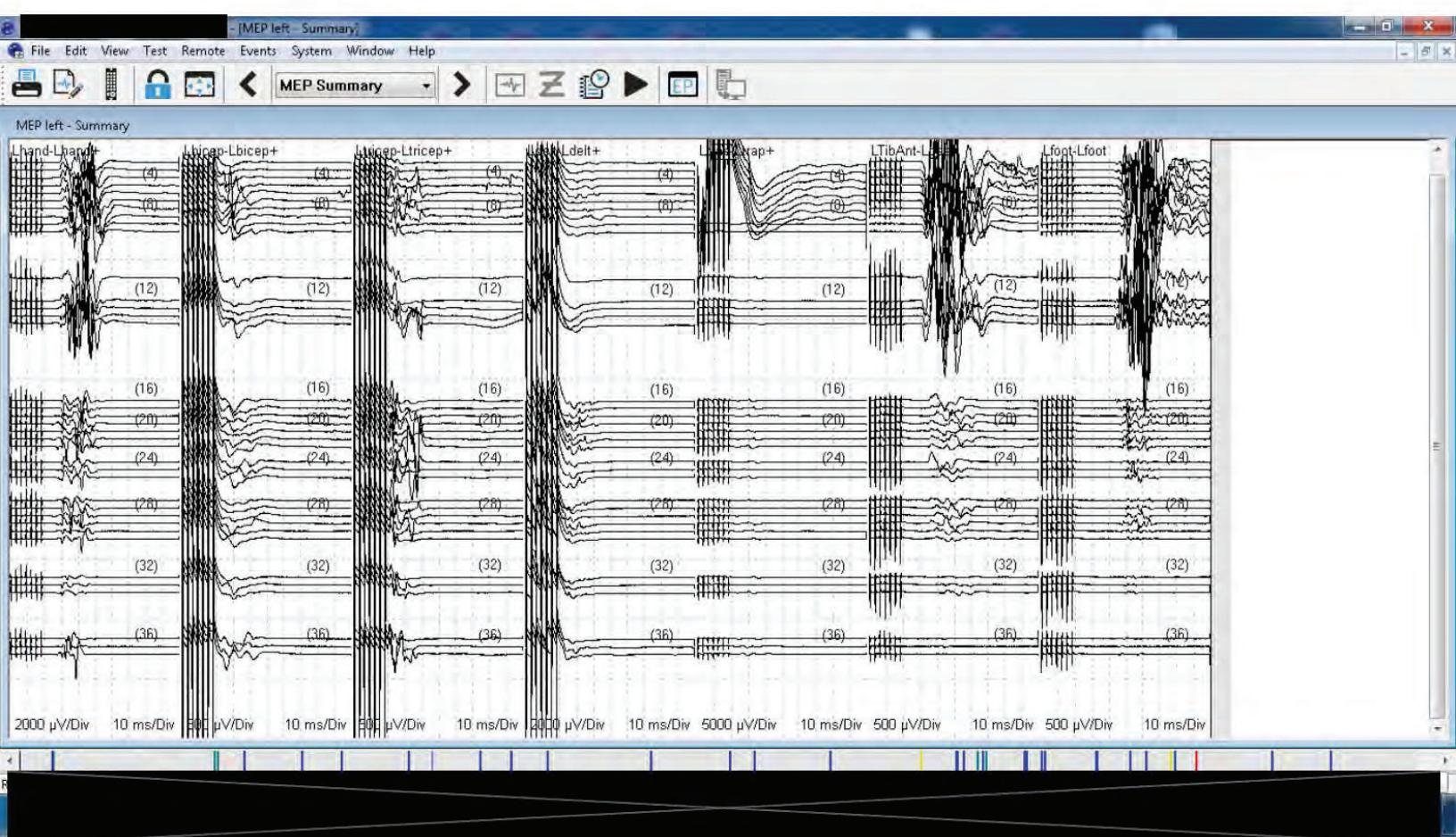
# Exhibit 38

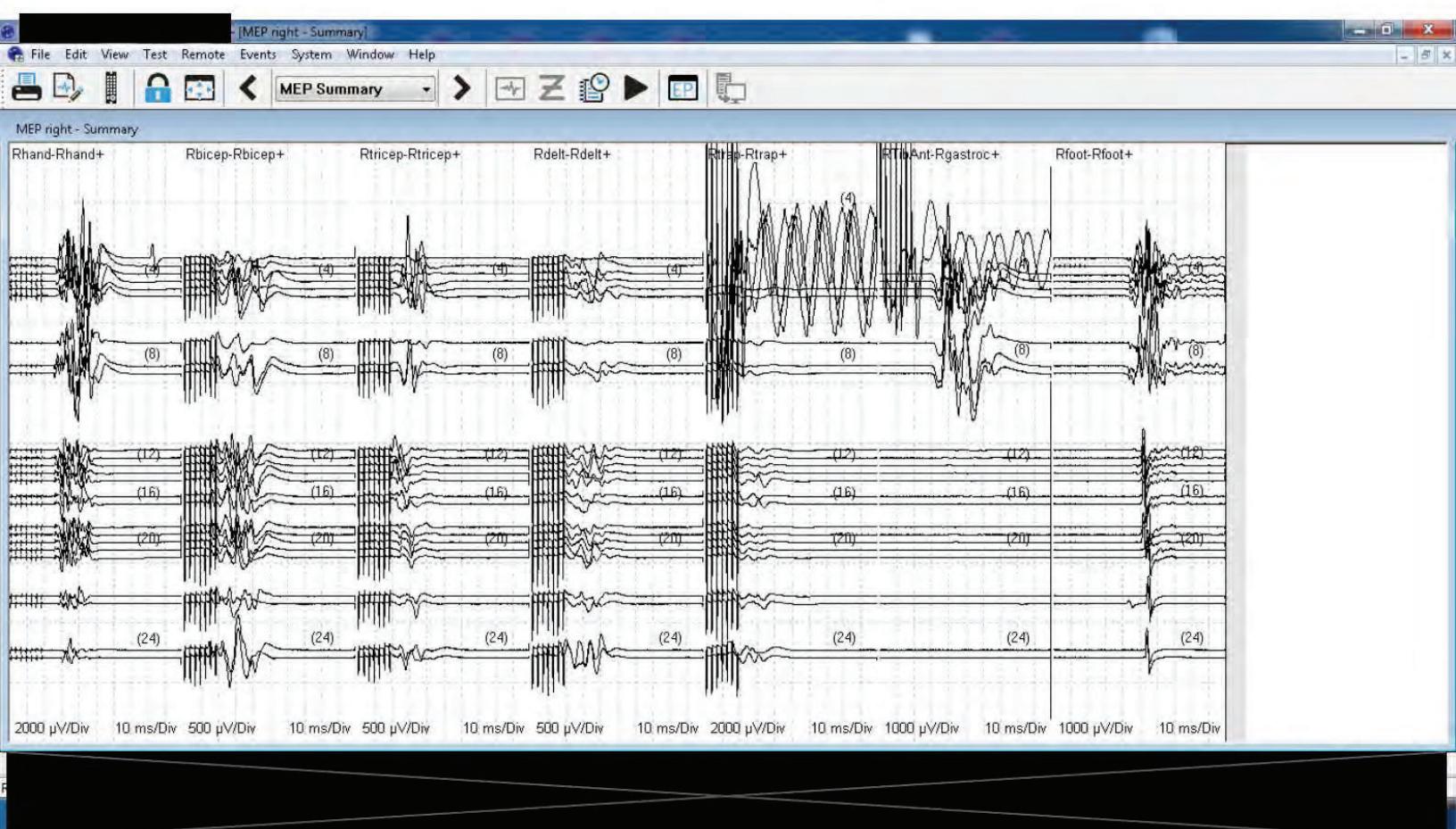






# Exhibit 39





# Exhibit 40

## UNIVERSITY OF SOUTHERN CALIFORNIA

## IOM Technologist, Sr./Administrator

Job Code: 187879

OT Eligible: No

Comp Approval: 9/3/2015

**JOB SUMMARY:**

Provides clinical oversight and training of technologists involved in the Intraoperative Neurophysiological Monitoring program at LAC+USC Medical Center within the Neurophysiology Program at USC. Creates and evaluates comprehensive technologist competencies to assess the technologist having suitable skills, knowledge, ability, training and experience to ensure quality services and patient safety in the various monitoring modalities. Administers program operations and administrative functions to include compliance with university/department policies and procedures and regulatory agencies, purchasing, quality control, short and long term planning, personnel administration, problem resolution and daily maintenance of patient data. Develops and recommends program operating and administrative policies. Schedules and assigns work of staff and third party organizations contracted for overflow. Works under minimal supervision on all phases of intraoperative neurophysiological monitoring. Performs all aspects of intraoperative neurophysiological monitoring independently to assess the functional integrity of the peripheral and/or central nervous system during vascular, orthopedic, and neurosurgical operative procedures on patients.

**JOB ACCOUNTABILITIES:****\*E/M/NA % TIME**

\_\_\_\_        Supervises and oversees technologists in the operating room. Provides guidance, direction and training, as required. Ensures delivery of comprehensive intraoperative neurophysiological monitoring services, compliance with university/department policies and regulatory agencies and quality control. Coordinates activities, etc.

\_\_\_\_        Plans, develops and implements training program for technologists. Develops and trains technologist in competencies of the various monitoring modalities. Demonstrates techniques, equipment and procedures to others.

\_\_\_\_        Creates comprehensive technologist competencies to assess quality in the various monitoring modalities and evaluates technologist competencies on a biyearly basis.

\_\_\_\_        Schedules and assigns work to staff and third party organizations contracted for overflow. Ensures appropriate staffing levels and makes adjustments as necessary. Reviews monitoring data, provides feedback, and ensures quality standards are maintained.

\_\_\_\_        Develops and maintains automated or manual systems and procedures to facilitate program operations.

\_\_\_\_        Identifies areas to broaden the scope of services. Determines modifications necessary for new surgical procedures.

\_\_\_\_        Develops, implements and recommends program operating and administrative policies. Conveys established policies and procedures.

\_\_\_\_\_\_ Performs all aspects of neurodiagnostic testing procedures independently, which include intraoperative room monitoring to assess the functional integrity of the peripheral and/or central nervous system during vascular, orthopedic, and neurosurgical operative procedures on patients of varying ages and medical conditions, in accordance with standards of practice. Uses electrophysiological methods, such as EEG, EMG, and evoked potentials to monitor the functional integrity of neural structures during surgery, utilizing a variety of sophisticated instruments.

\_\_\_\_\_\_ Serves as a key resource for program information. Resolves problems or questions referred by program staff or other individuals.

\_\_\_\_\_\_ Maintains equipment and supply inventories. Purchases equipment, as required

\_\_\_\_\_\_ Maintains compliance with established university and department policies and procedures, quality assurance, safety, environmental, infection control and complies with requirements of accreditation and regulatory agencies.

\_\_\_\_\_\_ Maintains patient data, daily. Generates reports of each monitored case and corresponding billing invoices for services rendered. Prepares data for physician review.

\_\_\_\_\_\_ Stays informed of developments in field, reading pertinent literature.

\_\_\_\_\_\_ Performs other related duties as assigned or requested. The university reserves the right to add or change duties at any time.

**\*Select E (ESSENTIAL), M (MARGINAL) or NA (NON-APPLICABLE) to denote importance of each job function to position.**

**EMERGENCY RESPONSE/RECOVERY:**

Essential:  No

Yes In the event of an emergency, the employee holding this position is required to "report to duty" in accordance with the university's Emergency Operations Plan and/or the employee's department's emergency response and/or recovery plans. Familiarity with those plans and regular training to implement those plans is required. During or immediately following an emergency, the employee will be notified to assist in the emergency response efforts, and mobilize other staff members if needed.

**JOB QUALIFICATIONS:**

**Minimum Education:**

Specialized/technical training

**Minimum Experience:**

3 years

**Minimum Field of Expertise:**

Graduate of an electroneurodiagnostic technology program accredited by the Committee on Allied Health Education or equivalent. Registration in electroencephalography and/or evoked potentials, and CNIM. Knowledge of neuro anatomy and physiology, electronics and electrical safety, knowledge of EEG/EP/EMG instrumentation, pattern recognition and various medical pharmacological conditions that influence an EEG and/or EP during surgery.

**Preferred Field of Expertise:**

American Board of Neurophysiologic Monitoring (ABNM) certified or eligible

**Skills: Administrative:**

- Assemble and organize numerical data
- Clinical documentation
- Compute totals
- Coordinate work of others
- Gather data
- Input data
- Understand and apply policies and procedures
- Use database and/or word processing software

**Skills: Other:**

- Analysis
- Assessment/evaluation
- Communication -- written and oral skills
- Interpretation of policies/analyses/trends/etc.
- Knowledge of applicable laws/policies/principles/etc.
- Lead/guidance skills
- Organization
- Planning
- Problem identification and resolution
- Project management
- Research
- Scheduling
- Teaching/training

**Skills: Laboratory:**

- Basic laboratory safety techniques
- Equipment maintenance
- Maintenance and monitoring of equipment
- Maintenance of records and documentation

**Skills: Machine/Equipment:**

- Calculator
- Computer network (department or school)
- Computer network (university)
- Computer peripheral equipment
- Fax
- Personal computer

**Supervises: Level:**

Leads one or more employees performing similar work.

**Supervises: Nature of Work:**

Technical

**SIGNATURES:**

**Employee:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**Supervisor:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**The above statements are intended to describe the general nature and level of work being performed. They are not intended to be construed as an exhaustive list of all responsibilities, duties and skills required of personnel so classified.**

**The University of Southern California is an Equal Opportunity Employer**

# **Exhibit 41**

Intraoperative Note  
\* Final Report \*

**\* Final Report \***

**Procedure Date:** 12/19/2017

**Study #:** LAC 17- 533

**Referring Physician:** Russin, M.D.

**Technician:** NN/ PP

**OR#:** 7

**Patient History:**

**Surgical Procedure:** Craniotomy for left temporal lobectomy

**MONITORING MODALITIES:**

SSEPs (somatosensory evoked potentials) TcMEPs (transcranial motor evoked potentials) and raw EEG.

**RESULTS:**

During the procedure the aforementioned modalities were continuously monitored.

The surgeon was informed at baseline that the patient's potentials amplitudes were adequate for monitoring bilaterally. These waveforms remained stable on left side throughout the procedure while motor evoked potentials become absent on right side during surgery. 7.5 hours were spent monitoring, and the surgeons were kept informed of the monitoring status and any significant changes.

**IMPRESSION:**

Somatosensory evoked potentials and Transcranial Motor evoked potentials were continuously monitored during surgery. The following changes were observed.

Motor evoked potentials become completely absent on right upper and lower extremity after resection which improved in right lower extremity after hemostasis while it remained absent in right upper extremity at closing.

Please see comment.

**COMMENT:** The changes seen in the right upper and lower extremity motor evoked potentials during surgery suggest that an interruption of this pathway occurred.

Clinical Correlation is strongly advised.

Further monitoring data is available by contacting the Intraoperative Neurophysiological Monitoring department.

**Signature Line**

Electronically Signed on 12/19/17 16:19 PST

Parikh, Pooja, Department

[REDACTED]

[REDACTED]

Operative Report  
\* Final Report \*

reaching the ambient cistern. A hole in the arachnoid was made using a micro scissor, allowing the release of CSF fluid and relaxation of the brain. As this relaxation occurred, the temporal lobe was retracted further using a combination of patties and Surgicel with gentle retraction using instruments with no permanent retractor, and the neuro navigation system was then used to confirm, in addition to anatomical navigation, that the collateral sulcus was found. This was then opened sharply using a combination of bipolar and micro scissors to the arachnoid and carefully separated. This was then opened down to the level of the ventricle, which was opened into. Then gentle opening of the ventricle in an anterior and posterior direction was done in order to expose the hippocampus as the hippocampus was exposed from the anterior most portion of the temporal horn to a posterior portion to the tail, which was safely able to be reached from our opening. This dissection was done with a combination of bipolar, A dissector, and Fukushima. Then a combination of CUSA, Fukushima and A dissector was used for a gentle subpial dissection to remove the hippocampus en bloc. This was done carefully, and the pia was separated from the hippocampus and the parahippocampal structures, taking care to leave the fusiform gyrus in place. The hippocampal artery and vein were identified and bipolarized. The neuro monitoring was used to monitor MEPs and SSEPs throughout the case, which were checked periodically approximately every 20-30 minutes. The hippocampal artery and vein were identified and then dissected, taking care not to take veins or arteries that were en passage. The CUSA was also used for an anterior disconnection at the level where the hippocampus met the uncus notch and posteriorly at the tail as far back as could be reached safely, which was also identified on neuro navigation to be at approximately the level of the aqueduct. Once this was done, the hippocampus was removed en bloc. At this time, a portion of the tail of the hippocampus was then resected using the CUSA, reaching back slightly further approximately 0.5 cm. Our attention was then turned toward the amygdala. The amygdala was removed in a subpial dissection. Once the amygdala was taken out, the MEPs were checked with no changes. However, approximately 15 minutes after that, the SSEPs were stable, but the MEPs were checked again, and at this time, there was a loss of motor evoked potentials on the patient's right side in hand and arm, leg and foot. The blood pressure was then raised, and the stimulation was turned up. However, there were still no motor evoked potentials on the right side. The patient was placed into burst suppression. The area was explored, and it was noted that this time that there was a disruption of the branches of the anterior choroidal artery that was reaching back. There was a disruption of this artery, and it appeared to be clotted. An attempt was made to open the artery by massaging the clot out, and ICG was used after this to verify to see if the artery was open, as it looked pulsatile. It was possible that there was some flow going through, but it was difficult to tell. There was no change in the motor evoked potentials at this time. After that, the area was hemostased using a combination of Surgicel and Gelfoam. The area was irrigated out copiously with LR with bacitracin. Once hemostasis was achieved, and the area was filled with irrigation, a 3 x 3 piece of suturable DuraGen was sutured into the dura which was then closed in a watertight fashion using 4-0 Nurolon and Tiseal was placed over the area. The bone was waxed with bone wax. The bone was replaced using Stryker plating system, and the temporalis was reapproximated using 2-0 Vicryl. The galea was reapproximated using 2-0 Vicryl. The skin was closed using a 3-0 Monocryl, and a combination of bacitracin, gauze and paper tape was used to cover the wounds. Upon closing, the patient was taken out of burst suppression, and then woken up after closing was completed. Upon waking up, it was noted the patient was not moving his right side, but was moving the left side well. After giving him time to wake up further, he was moving his left side without issue and was withdrawing slightly with 2/5 in his lower extremity on the right and no movement was noted in his right upper extremity. He was also noted to have a right-sided facial. The patient was extubated and taken to the ICU for further care with increased blood pressure. Goal of SBP 140-160.

**COMPLICATION:** Anterior choroidal perforating artery stroke with loss of motor evoked potentials and loss of motor strength on the right side

**BLOOD LOSS:** 100

**FLUIDS:** As per Anesthesia.

**DRAINS:** None.

**POSITION:** To the neurosurgical ICU. This was discussed with Dr. Russin and Dr. Mehta, who agreed. While the patient was being closed, Dr. Russin spoke with the family to let them know that the motor evoked potentials had dropped. Then following the surgery and following the patient waking up, the family, the patient's sister, was informed of his weakness and told that this deficit could be permanent. All questions were answered, and it was stated that this was a complication of surgery. The patient's <sup>Page 3</sup> ~~Page 3~~ (Continued)

Operative Report  
\* Final Report \*

she understood, and all concerns were addressed. This event was reported to the central reporting agency for our hospital within 24 hours. An MRJ was also obtained to confirm the stroke, which was confirmed on postoperative MRI. This was discussed with Dr. Russin and Dr. Mehta, who agreed.

Dictated By: Daniel Richard Kramer, MD

Vivek Mehta.

DRK/MODL

JOB #: 

**Signature Line**

Electronically Signed on 12/28/17 13:45 PST

Kramer, Daniel Richard, MD

Acosta, Frank L., MD.

Neurosurgery Inpatient Progress Note

\* Final Report \*



**\* Final Report \***

postop check:

E3M6V4

sleepy, arousable to verbal stim, oriented 2x  
OU 5-3

speech dysarthric, few words

R facial droop, able to close both eyes fully

LUE follows commands

RUE no mvmnt to max stim

LLE follows commands

RLE weak antigravity to max stim

surgical incision c/d/i, island dressing in place

Lee/Bonney

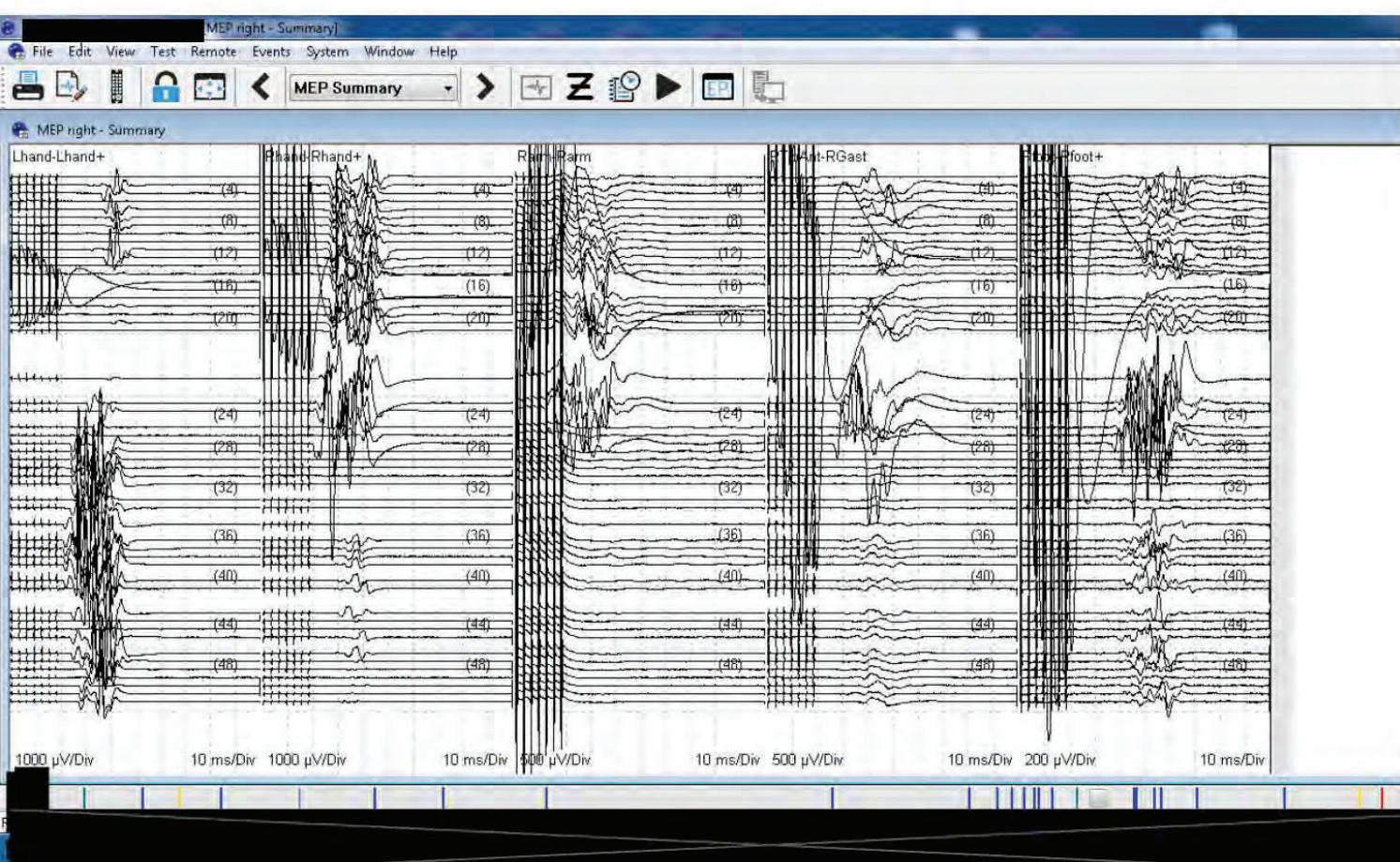
Att Mehta

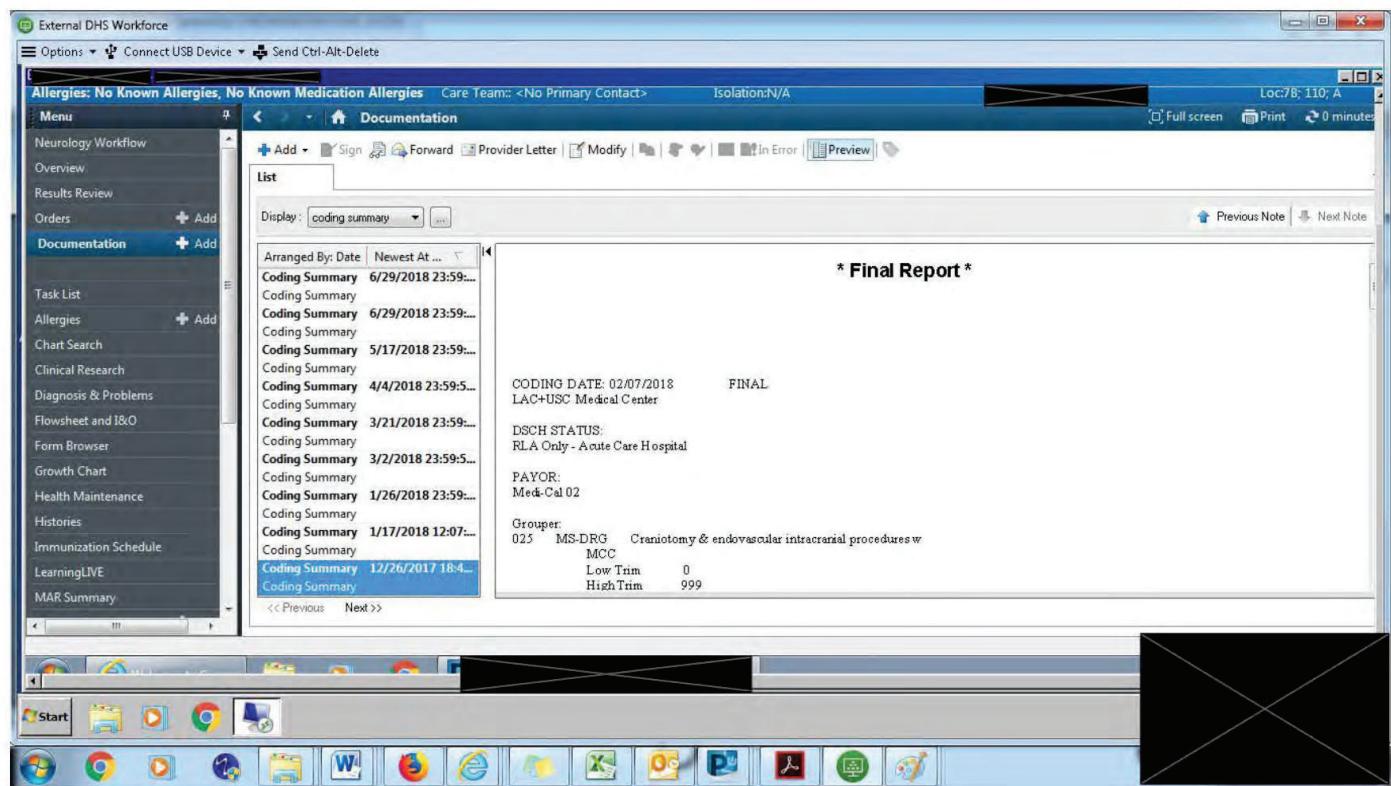
Att Russin

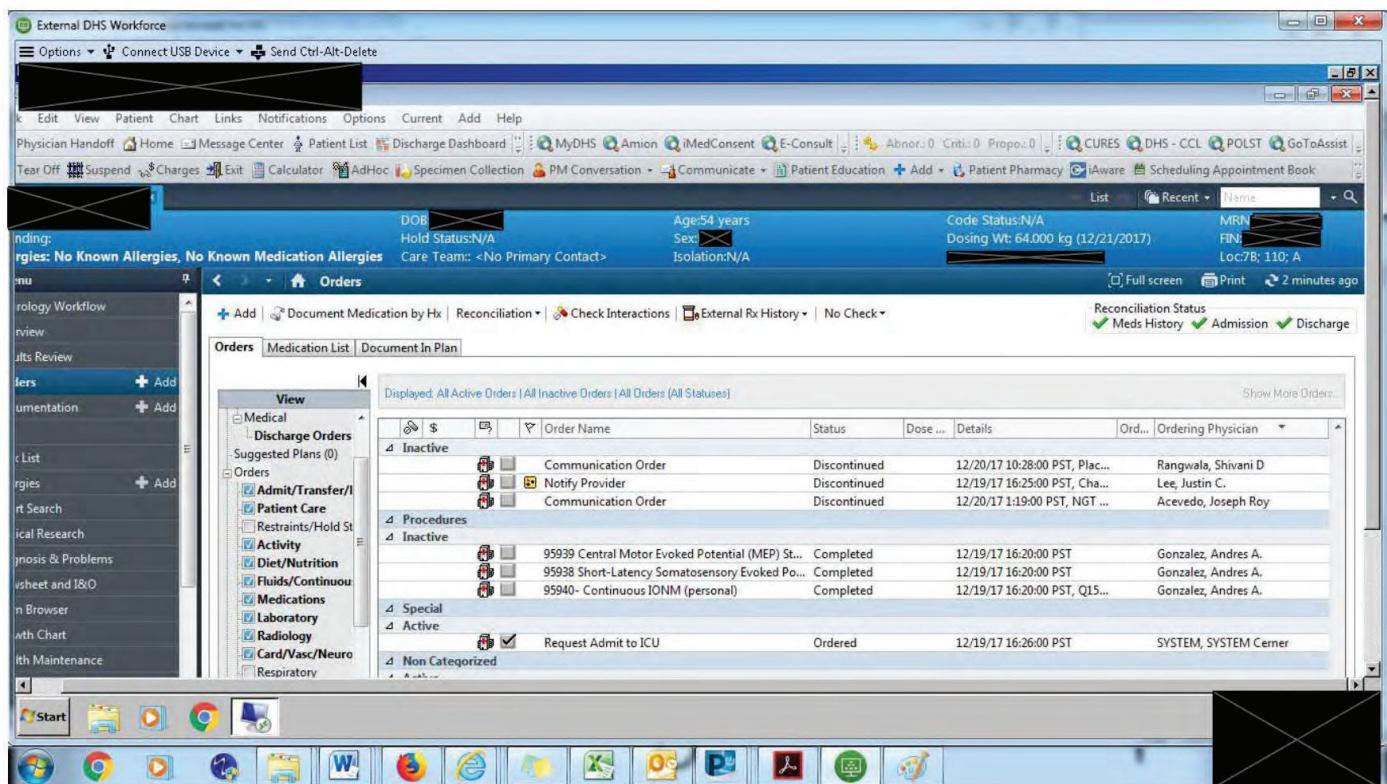
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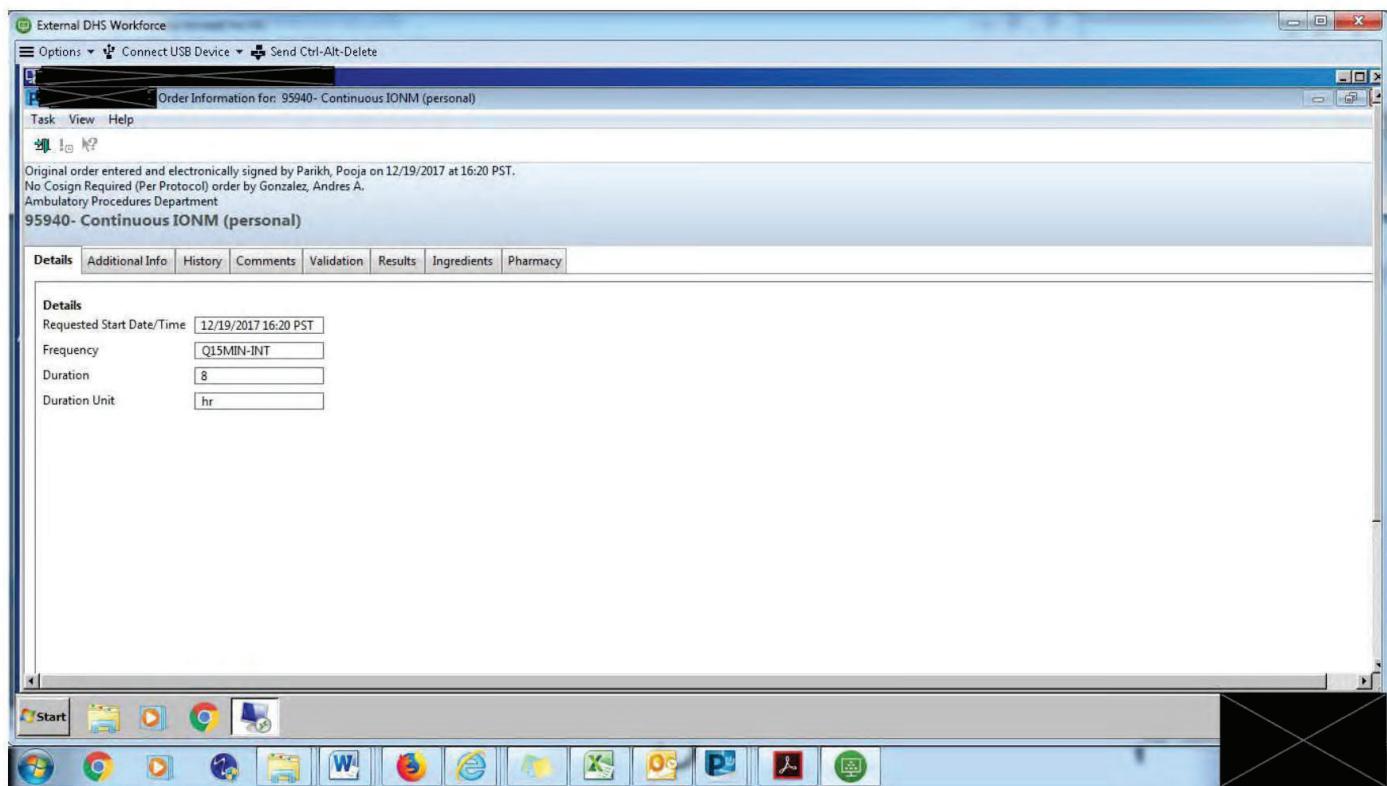
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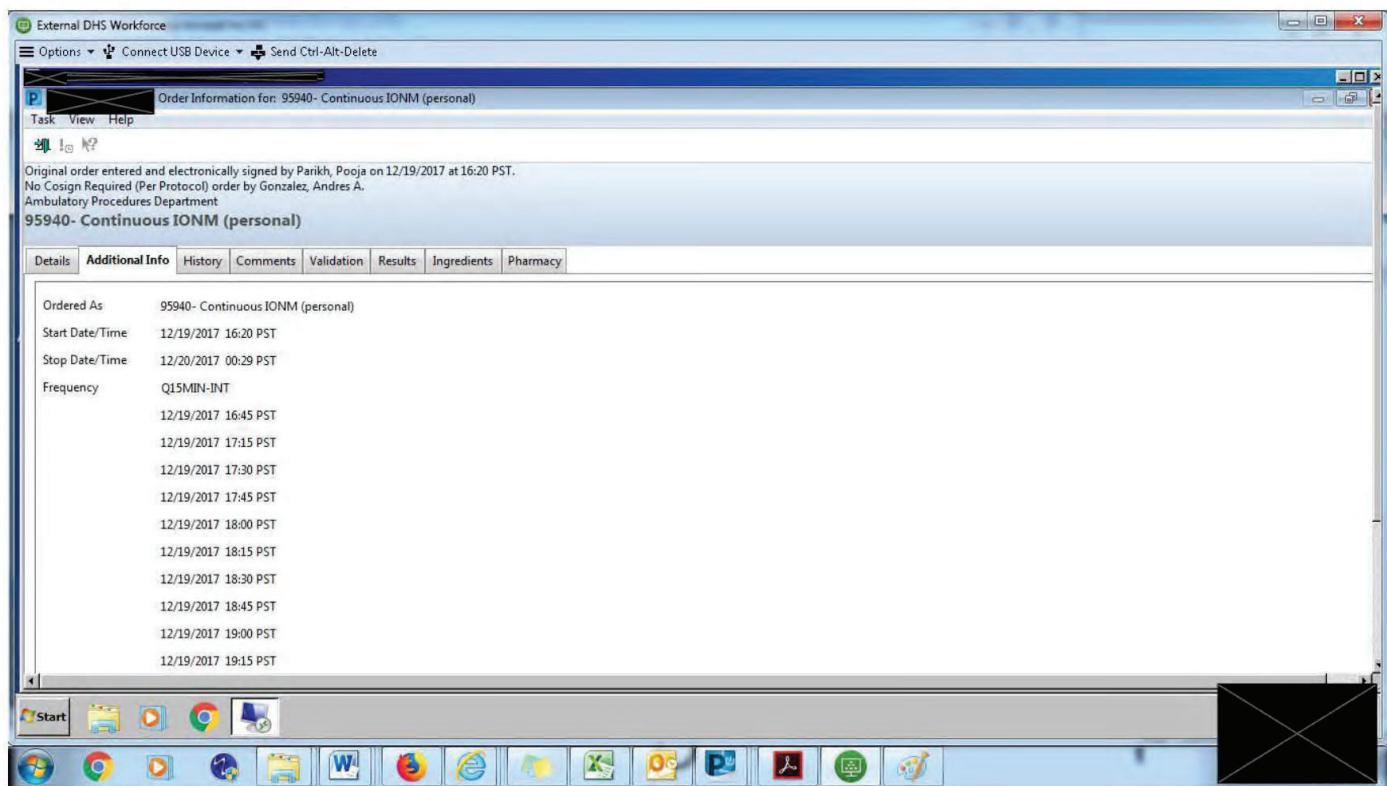
Lee, Justin C., MD.

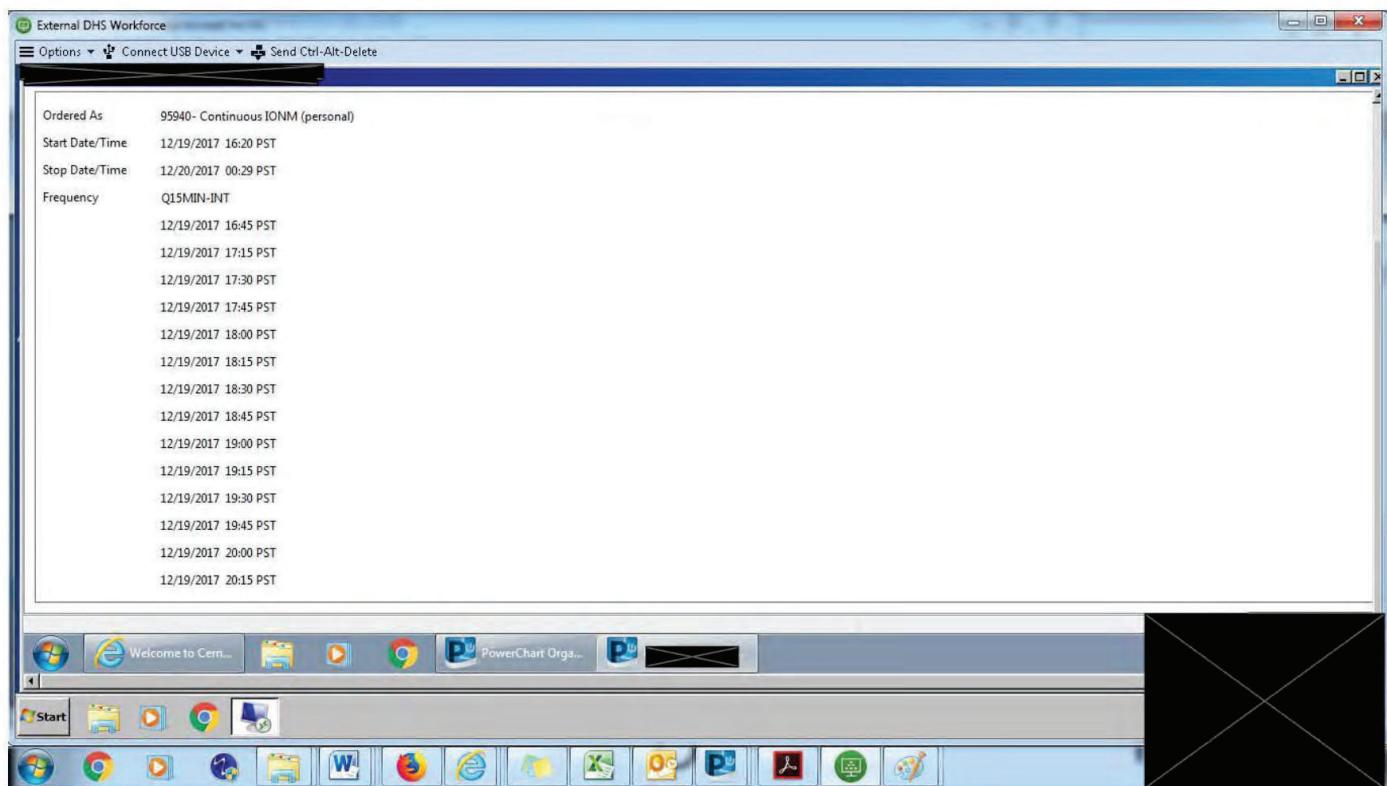


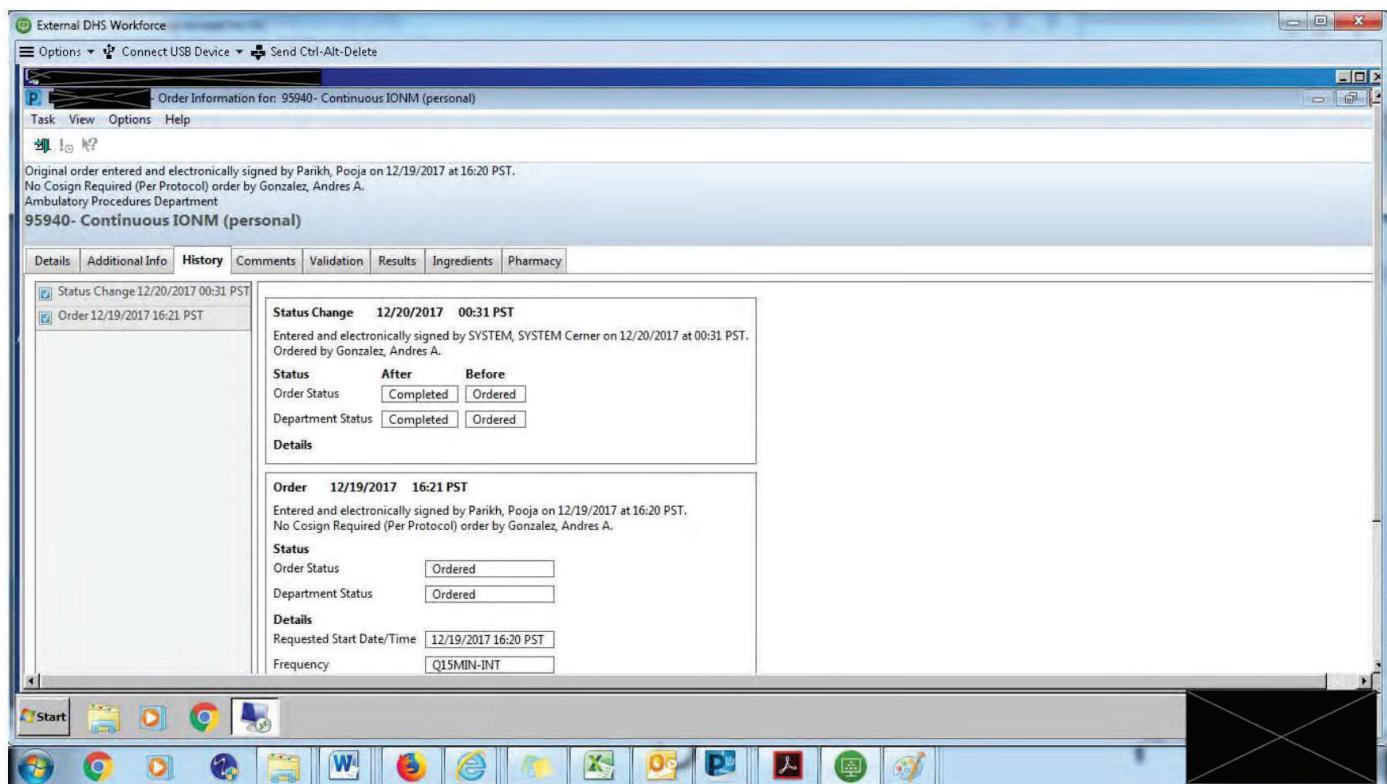


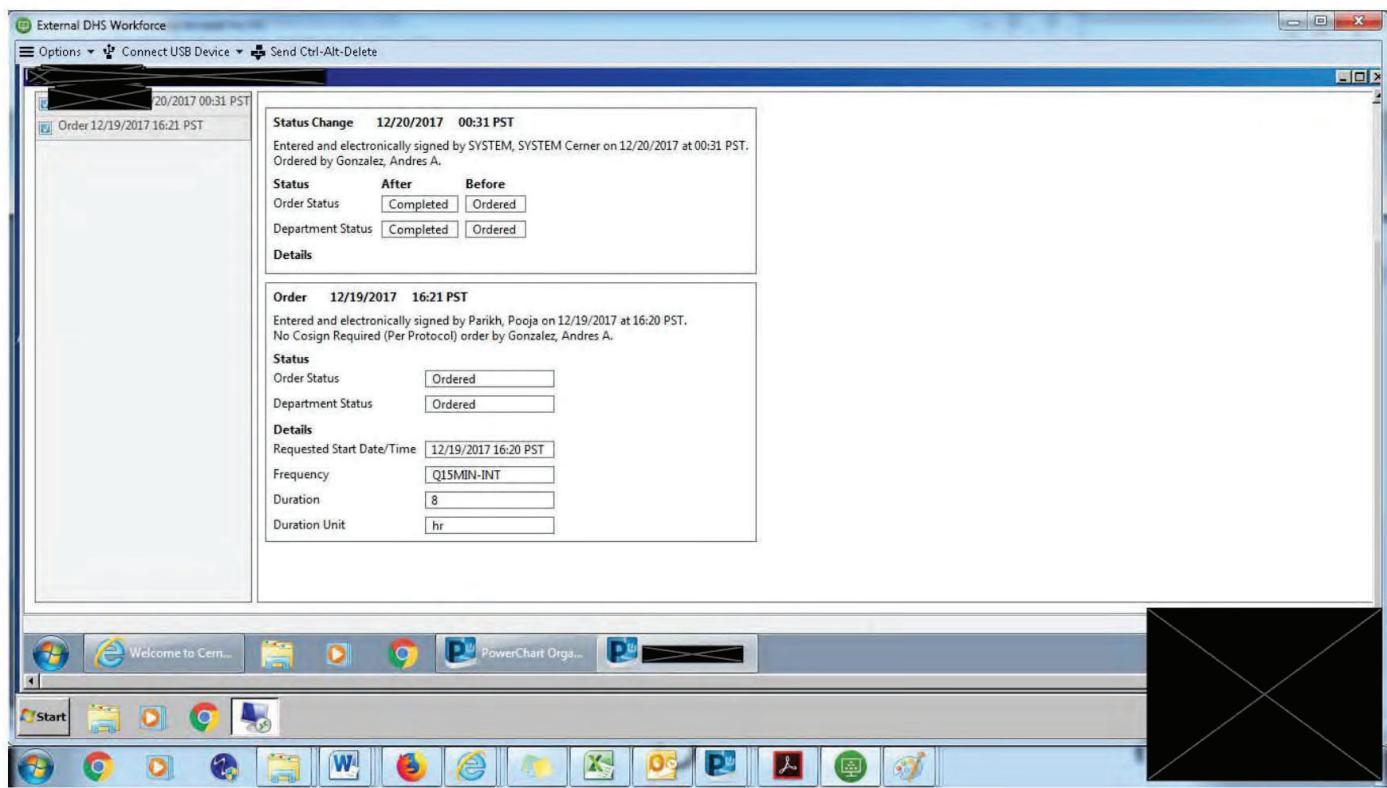


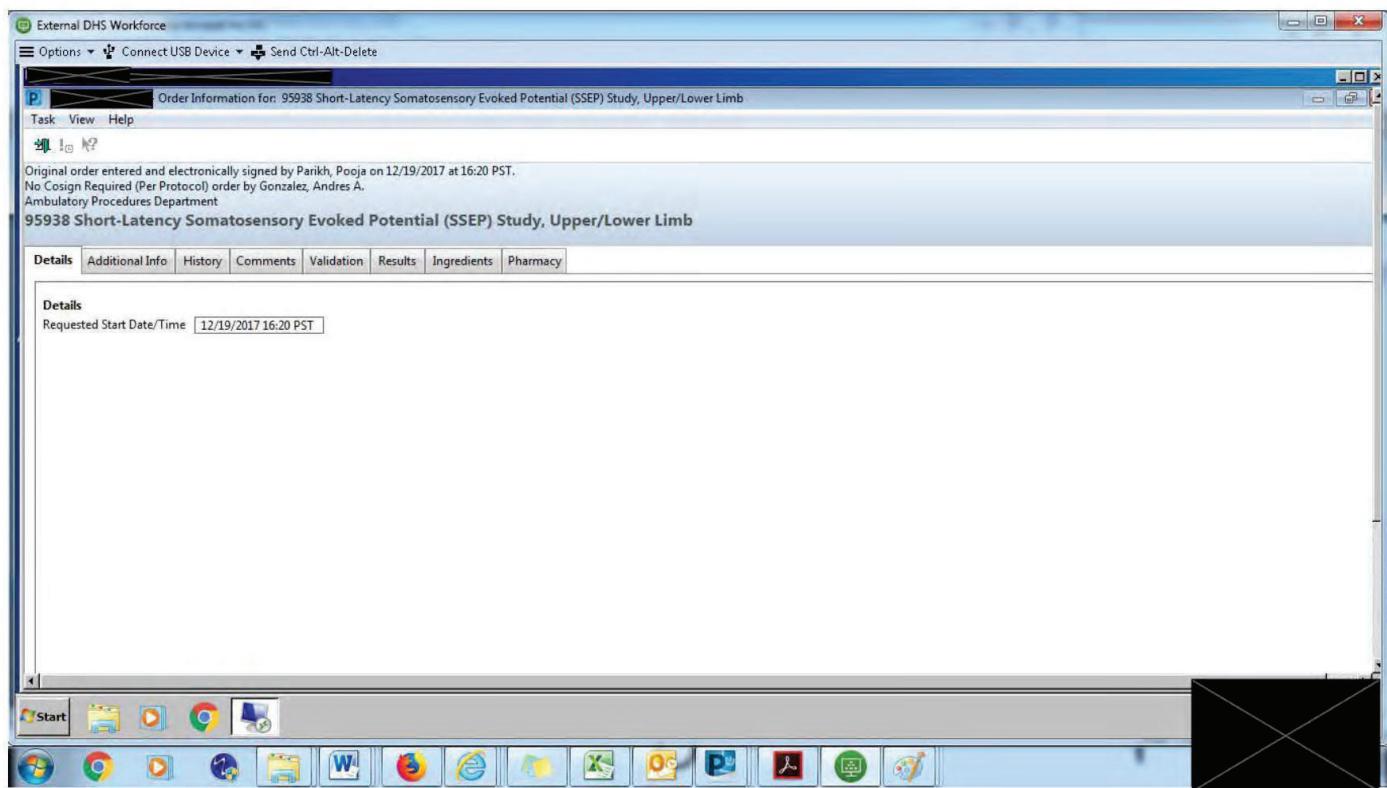


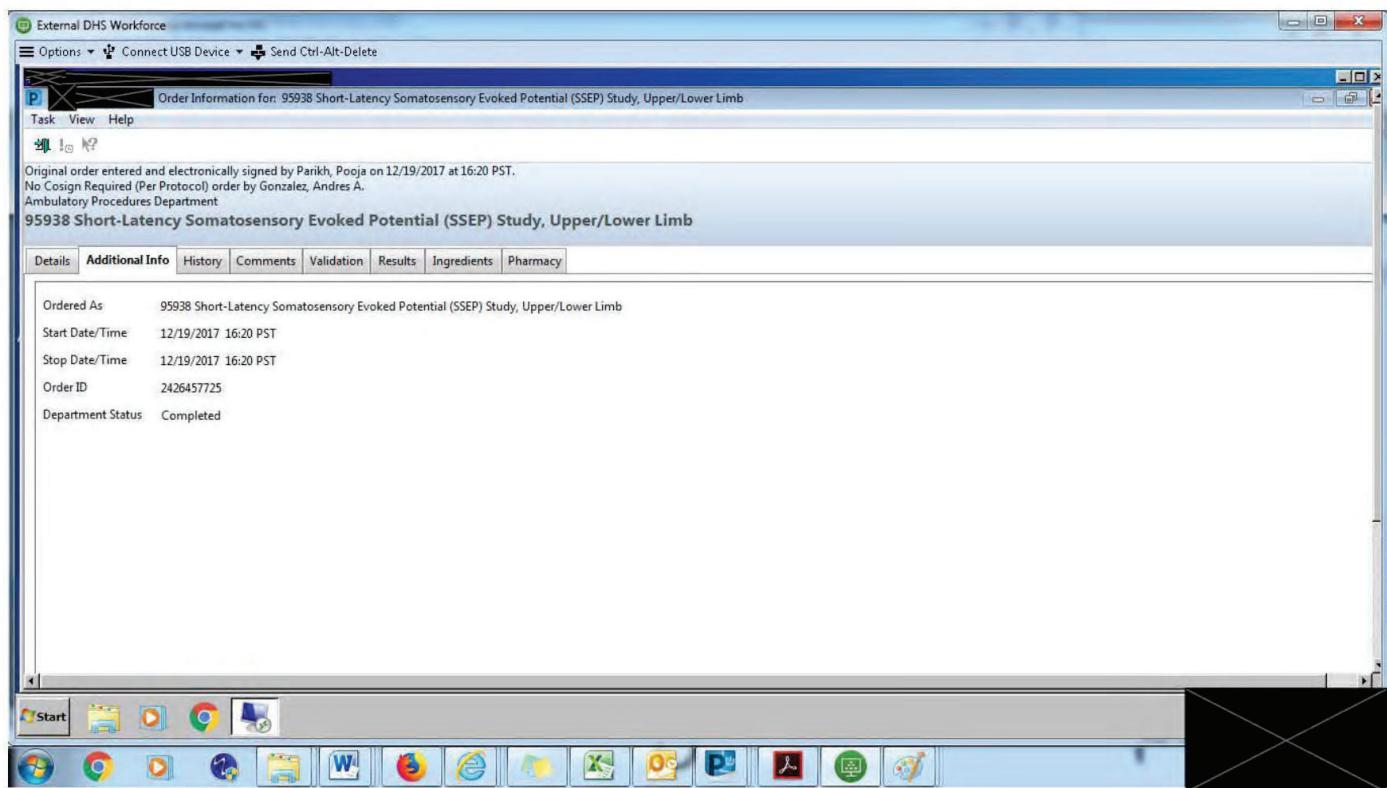


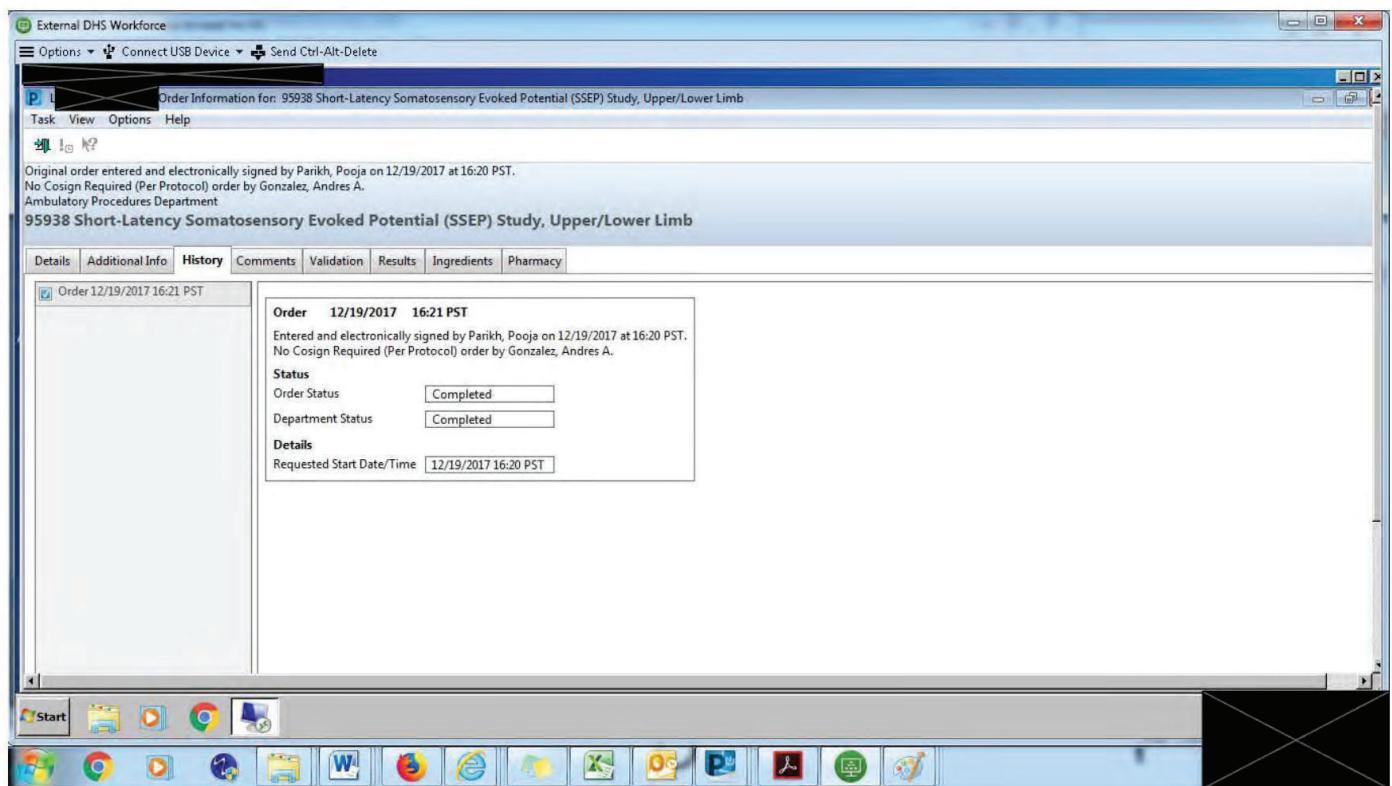


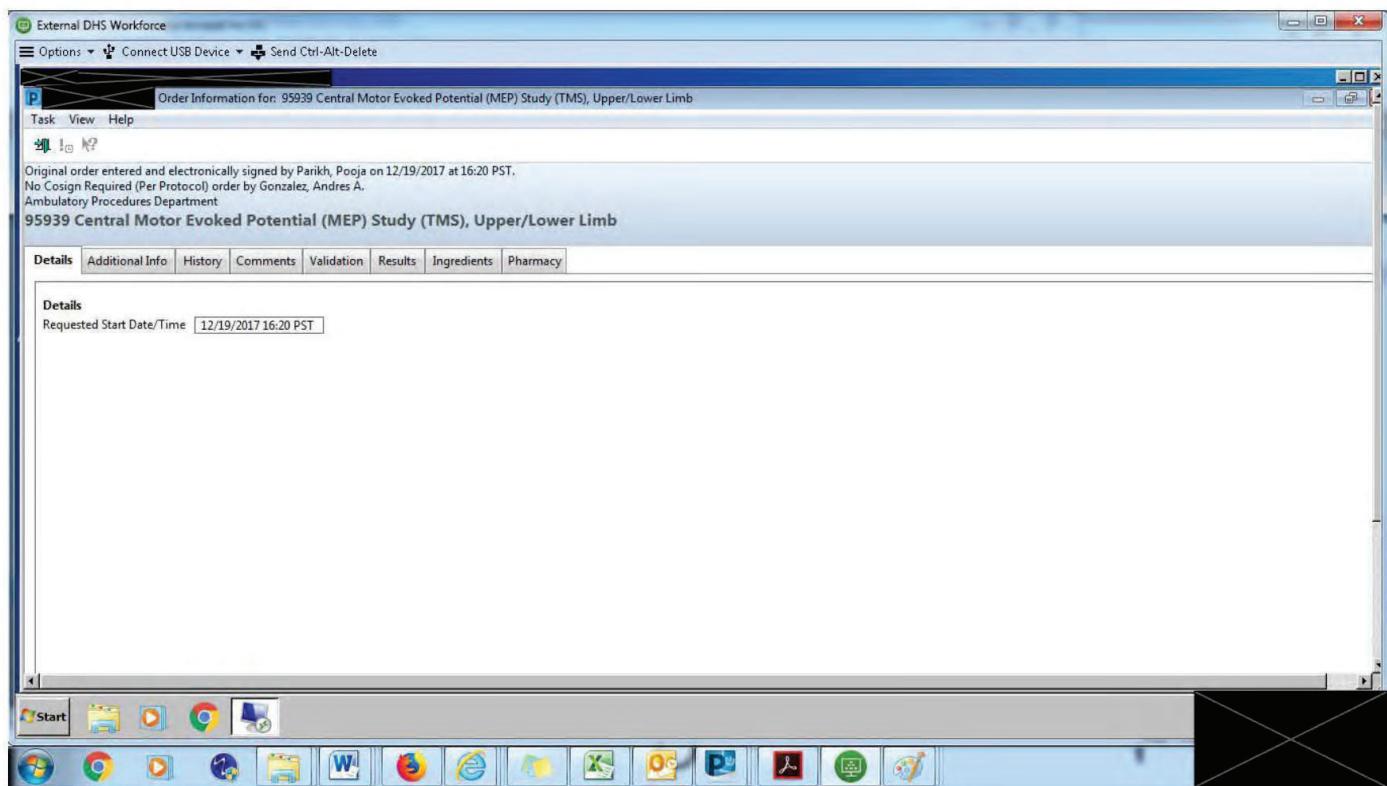


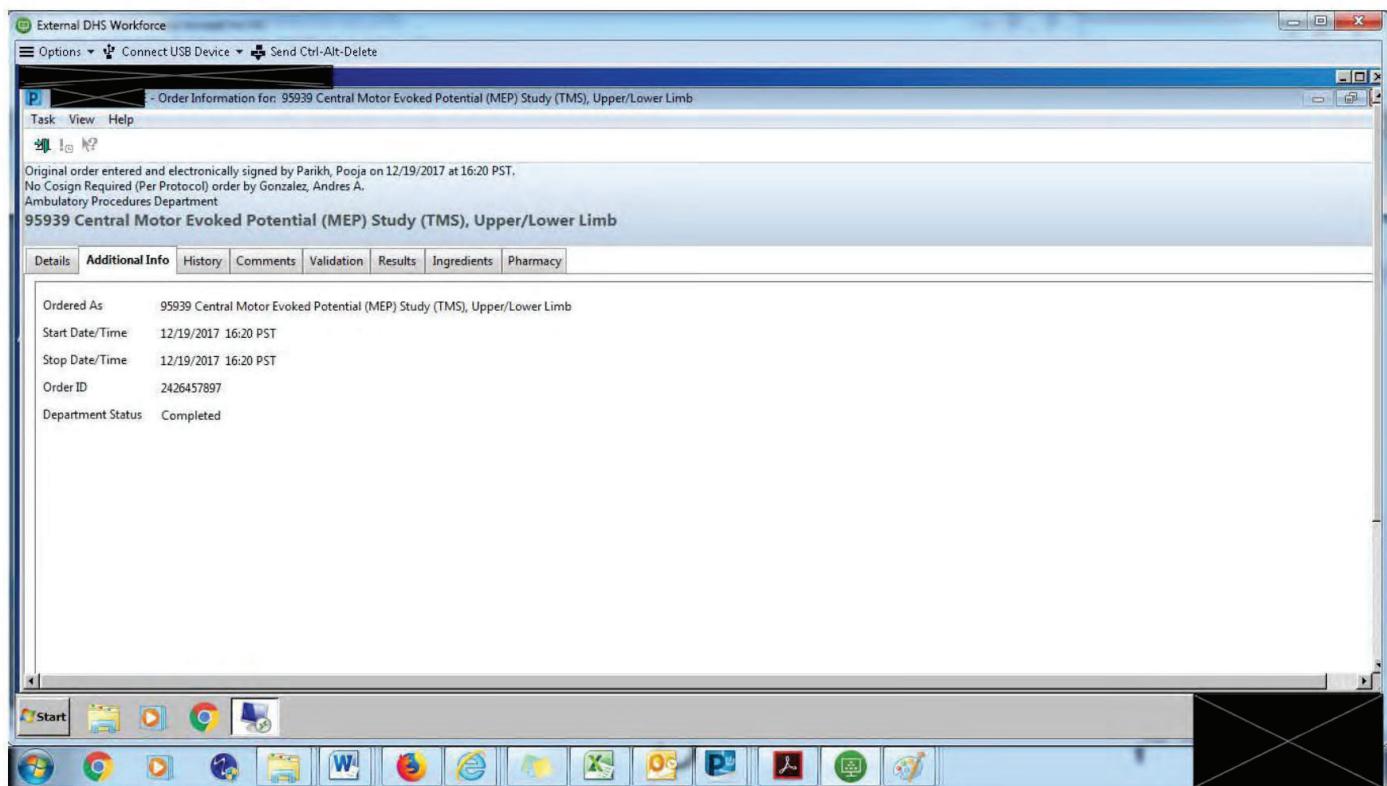


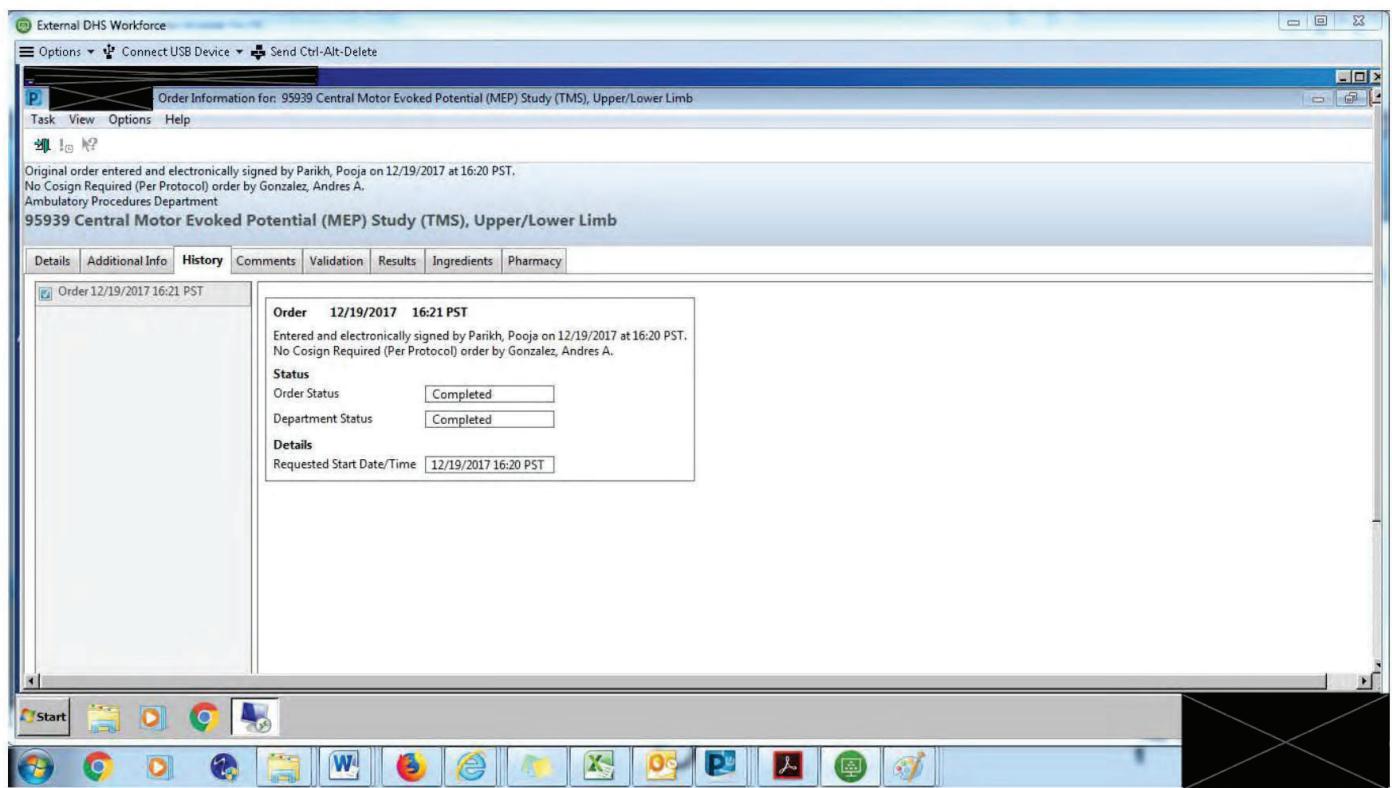












Intraoperative Note  
\* Final Report \*

**\* Final Report \***

**Procedure Date:** 12/19/2017  
**Referring Physician:** Russin, M.D.  
**OR#:** 7  
**Patient History:**  
**Surgical Procedure:** Craniotomy for left temporal lobectomy

**Study #:** LAC 17- 533  
**Technician:** NN/ PP

**MONITORING MODALITIES:**  
SSEPs (somatosensory evoked potentials) TcMEPs (transcranial motor evoked potentials) and raw EEG.

**RESULTS:**

During the procedure the aforementioned modalities were continuously monitored.

The surgeon was informed at baseline that the patient's potentials amplitudes were adequate for monitoring bilaterally. These waveforms remained stable on left side throughout the procedure while motor evoked potentials become absent on right side during surgery. 7.5 hours were spent monitoring, and the surgeons were kept informed of the monitoring status and any significant changes.

**IMPRESSION:**

Somatosensory evoked potentials and Transcranial Motor evoked potentials were continuously monitored during surgery. The following changes were observed.  
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Please see comment.

**COMMENT:** The changes seen in the right upper and lower extremity motor evoked potentials during surgery suggest that an interruption of this pathway occurred.

Clinical Correlation is strongly advised.

Further monitoring data is available by contacting the Intraoperative Neurophysiological Monitoring department.

**Signature Line**  
Electronically Signed on 12/19/17 16:19 PST

Parikh, Pooja, Department

3 PS The

Operative Report  
\* Final Report \*

**\* Final Report \***

**Operative Report (Verified)**

**REPORT OF OPERATION**

**DEPARTMENT: NEUROLOGICAL SURGERY-NS DATE OF OPERATION: December 19, 2017**

**ATTENDING SURGEON: Vivek Mehta**

**DICTATED BY: Daniel Richard Kramer, MD**

**OPERATING SURGEON: Daniel Richard Kramer, MD**

**PREOPERATIVE DIAGNOSIS: Intractable epilepsy.**

**POSTOPERATIVE DIAGNOSIS: Intractable epilepsy and stroke.**

**PROCEDURE PERFORMED: Left-sided selective amygdalohippocampectomy.**

**ADDITIONAL ATTENDING SURGEON: Jonathan J. Russin, MD**

**INDICATIONS FOR PROCEDURE:** This is a 53-year-old, Spanish speaking, ambidextrous male with a past medical history of intractable epilepsy who underwent EEG at Rancho Los Amigos which showed left-sided seizures. This was consistent with left greater than right mesial temporal sclerosis, as seen on MRI. A WADA was conducted which showed that he was a good candidate for a left-sided resection, and after discussion at epilepsy conference, it was determined that he was a good candidate for a left sided amygdalohippocampectomy. The patient was brought into clinic prior to surgery, and the options of surgery versus no surgery were discussed with him, and the procedure was explained in detail including the risks, benefits and alternatives including, but not limited to, bleeding, infection, visual field deficit, minimal or no improvement in seizure burden or severity, weakness, numbness, stroke, paralysis, heart attack, coma and death. All questions and concerns were addressed. The patient and the sister were both present and agreed to surgery, and the patient signed a consent form and then preoperative evaluation done, and he was deemed a good candidate for surgery.

**PROCEDURE:** On the date of surgery, the patient was brought into the operating room, and placed under general anesthesia in the usual fashion. A surgical pause was done correctly identifying the patient, procedure, and side. Surgical monitoring of the MEPs and SSEPs was done throughout the case. Surgical navigation was set up prior to surgery. The patient was then prepped and draped in the usual fashion. The patient was placed in the Mayfield holder, and a linear incision was drawn above the root of zygoma about 6 cm above the ear. Following the timeout, this area was injected with 0.5% lidocaine with epinephrine. The skin was opened with a #10 blade. A combination of bipolar and monopolar cautery was used for hemostasis, and dissection was done down to the temporalis fascia and then through the temporalis and down to the bone. This area was then retracted using a curved cerebellar retractor, and the bone was exposed. A perforator drill was used to make a burr hole at the root of zygoma, and a combination of Fukushima and #3 Penfield was used to dissect the dura from underneath the cranium. A craniotome was then used to make a craniectomy. This bone was removed, and a 5 extra coarse diamond was used to drill down to the root of zygoma and far forward and then also posterior in order to make an opening wide enough for dissection. Hemostasis was achieved with a combination of Surgicel and bipolar cautery. The dura was then opened with a 15 blade, and bipolar cautery was used for hemostasis. At this time, the surgical microscope was brought. The temporal lobe was lifted from the temporal floor gently without the use of retractors until

Operative Report  
\* Final Report \*

reaching the ambient cistern. A hole in the arachnoid was made using a micro scissor, allowing the release of CSF fluid and relaxation of the brain. As this relaxation occurred, the temporal lobe was retracted further using a combination of patties and Surgicel with gentle retraction using instruments with no permanent retractor, and the neuro navigation system was then used to confirm, in addition to anatomical navigation, that the collateral sulcus was found. This was then opened sharply using a combination of bipolar and micro scissors to the arachnoid and carefully separated. This was then opened down to the level of the ventricle, which was opened into. Then gentle opening of the ventricle in an anterior and posterior direction was done in order to expose the hippocampus as the hippocampus was exposed from the anteriormost portion of the temporal horn to a posterior portion to the tail, which was safely able to be reached from our opening. This dissection was done with a combination of bipolar, A dissector, and Fukushima. Then a combination of CUSA, Fukushima and A dissector was used for a gentle subpial dissection to remove the hippocampus en bloc. This was done carefully, and the pia was separated from the hippocampus and the parahippocampal structures, taking care to leave the fusiform gyrus in place. The hippocampal artery and vein were identified and bipolarized. The neuro monitoring was used to monitor MEPs and SSEPs throughout the case, which were checked periodically approximately every 20-30 minutes. The hippocampal artery and vein were identified and then dissected, taking care not to take veins or arteries that were en passage. The CUSA was also used for an anterior disconnection at the level where the hippocampus met the uncus notch and posteriorly at the tail as far back as could be reached safely, which was also identified on neuro navigation to be at approximately the level of the aqueduct. Once this was done, the hippocampus was removed en bloc. At this time, a portion of the tail of the hippocampus was then resected using the CUSA, reaching back slightly further approximately 0.5 cm. Our attention was then turned toward the amygdala. The amygdala was removed in a subpial dissection. Once the amygdala was taken out, the MEPs were checked with no changes. However, approximately 15 minutes after that, the SSEPs were stable, but the MEPs were checked again, and at this time, there was a loss of motor evoked potentials on the patient's right side in hand and arm, leg and foot. The blood pressure was then raised, and the stimulation was turned up. However, there were still no motor evoked potentials on the right side. The patient was placed into burst suppression. The area was explored, and it was noted that this time that there was a disruption of the branches of the anterior choroidal artery that was reaching back. There was a disruption of this artery, and it appeared to be clotted. An attempt was made to open the artery by massaging the clot out, and ICG was used after this to verify to see if the artery was open, as it looked pulsatile. It was possible that there was some flow going through, but it was difficult to tell. There was no change in the motor evoked potentials at this time. After that, the area was hemostased using a combination of Surgicel and Gelfoam. The area was irrigated out copiously with LR with bacitracin. Once hemostasis was achieved, and the area was filled with irrigation, a 3 x 3 piece of suturable DuraGen was sutured into the dura which was then closed in a watertight fashion using 4-0 Nurolon and Tiseal was placed over the area. The bone was waxed with bone wax. The bone was replaced using Stryker plating system, and the temporalis was reapproximated using 2-0 Vicryl. The galea was reapproximated using 2-0 Vicryl. The skin was closed using a 3-0 Monocryl, and a combination of bacitracin, gauze and paper tape was used to cover the wounds. Upon closing, the patient was taken out of burst suppression, and then woken up after closing was completed. Upon waking up, it was noted the patient was not moving his right side, but was moving the left side well. After giving him time to wake up further, he was moving his left side without issue and was withdrawing slightly with 2/5 in his lower extremity on the right and no movement was noted in his right upper extremity. He was also noted to have a right-sided facial. The patient was extubated and taken to the ICU for further care with increased blood pressure. Goal of SBP 140-160.

**COMPLICATION:** Anterior choroidal perforating artery stroke with loss of motor evoked potentials and loss of motor strength on the right side.

**BLOOD LOSS:** 100.

**FLUIDS:** As per Anesthesia.

**IRAINS:** None.

**POSITION:** To the neurosurgical ICU. This was discussed with Dr. Russin and Dr. Mehta, who agreed. While the patient was being closed, Dr. Russin spoke with the family to let them know that the motor evoked potentials had dropped. Then following the surgery and following the patient waking up, the family, the patient's sister, was informed of his weakness and told that this deficit could be permanent. All questions were answered, and it was stated that this was a complication of surgery. The patient's Page 2 of 3 (Continued)

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she understood, and all concerns were addressed. This event was reported to the central reporting agency for our hospital within 24 hours. An MRI was also obtained to confirm the stroke, which was confirmed on postoperative MRI. This was discussed with Dr. Russin and Dr. Mehta, who agreed.

Dictated By: Daniel Richard Kramer, MD

Vivek Mehta.

DRK/MODL

JOB #: A horizontal black redaction box consisting of a series of small diamond shapes.

**Signature Line**

Electronically Signed on 12/28/17 13:45 PST

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Kramer, Daniel Richard, MD

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Acosta, Frank L., MD.

Neurosurgery Inpatient Progress Note

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postop check:  
E3M6V4  
sleepy, arousable to verbal stim, oriented 2x  
OU 5-3  
speech dysarthric, few words  
R facial droop, able to close both eyes fully  
LUE follows commands  
RUE no mvmnt to max stim  
LLE follows commands  
RLE weak antigravity to max stim

surgical incision c/d/i, island dressing in place

Lee/Bonney  
Att Mehta  
Att Russin

**Signature Line**

Electronically Signed on 12/21/17 09:03 PST

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Lee, Justin C., MD.



Page 1 of 1  
(End of Report)

in OR Intraoperative Record  
nal Report \*

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**> Main OR Intraop Nursing Record (Verified)**

**SC Main OR Intraop Nursing Record Summary**

Primary Physician: Mehta, Vivek A.  
Case Number: USCOR-2017-18000  
Normalized Date/Time: 12/19/17 17:14:00  
Patient Name: [REDACTED]  
O.B./Sex: Male  
Ad Rec #: [REDACTED]  
Physician: Lucas, Joshua W.  
Financial #: [REDACTED]  
Type: I  
Room/Bed: 150/A  
Admit/Disch: 12/19/17 04:46:21 -  
Institution: [REDACTED]

**Safety Checklist 2) Time Out - USC MOR**

**Pre-Care Text:**

A.10 Confirms patient identity A.20 Verifies operative procedure, surgical site, and laterality A.20.1 Verifies consent for planned procedure A.30 Verifies allergies

Entry 1

Final Time Out was conducted based on the DHS Final Time Out	Yes	Comments	N/A
Checklist/Standards: A.1 Time Out participants ceased activity, confirmed patient, site, procedure, and consents	Yes	Comments	N/A
Time Out Members	Mehta, Vivek A., Lee, Justin C., Lee, Jessica, Sam RN, John, Hunanyan, Arsen, Nguyen, Nancy, Kramer, Daniel Richard	Time Out Time	12/19/17 08:52:00

**Post-Care Text:**

E.30 Evaluates verification process for correct patient, site, side, and level surgery

**Surgical Procedures - USC MOR**

**Pre-Care Text:**

A.20 Verifies operative procedure, surgical site, and laterality A.20.2 Assesses the risk for unintended retained foreign body Im.20 Performs required counts

Entry 1

Procedure Description	Craniotomy	Procedure Code	CRANIOT LOBECTOMY
Additional Procedure Detail	left temporal lobectomy		OTH/THN TEMPORAL LOBE W/ECOG

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Primary Procedure	Yes	Attending Surgeon of Record	Lucas, Joshua W.
Start	12/19/17 08:52:00	Stop	12/19/17 16:18:00
Anesthesia Type	General	Surgical Service	Neurosurgery (SN)
Sound Class	1-Clean		

**Post-Care Text:**

O.730 The patient's care is consistent with the individualized perioperative plan of care

**Case Times - USC MOR**

	Entry 1		
Patient			
Patient In Room Time	12/19/17 07:27:00	Patient Out Room Time	12/19/17 17:00:00
Use			
Procedure Start Time	12/19/17 08:52:00	Procedure Stop Time	12/19/17 16:18:00

**Case Attendance - USC MOR**

	Entry 1	Entry 2	Entry 3
Use Attendee	Mehta, Vivek A.	Lee, Justin C.	Lee, Jessica
Role Performed	Surgeon - Attending	Surgical Resident	Anesthesia Resident
me In	12/19/17 07:27:00	12/19/17 07:27:00	12/19/17 07:24:00
me Out	12/19/17 17:00:00	12/19/17 17:00:00	12/19/17 17:00:00
Procedure(s)	Craniotomy	Craniotomy	Craniotomy
	Entry 4	Entry 5	Entry 6
Use Attendee	Sam RN, John	Rosario RN, Judith	Hunanyan, Arsen
Role Performed	Circulator - Primary	Circulator - Relief	Scrub - Primary
me In	12/19/17 07:27:00	12/19/17 07:35:00	12/19/17 07:27:00
me Out	12/19/17 17:00:00	12/19/17 07:50:00	12/19/17 17:00:00
Procedure(s)	Craniotomy	Craniotomy	Craniotomy
	Entry 7	Entry 8	Entry 9
Use Attendee	Kramer, Daniel Richard	Nguyen, Nancy	Seidner RN, Jessica
Role Performed	Fellow	Other Authorized Personnel	Scrub - Relief
me In	12/19/17 07:27:00	12/19/17 07:27:00	12/19/17 11:45:00
me Out	12/19/17 17:00:00	12/19/17 17:00:00	12/19/17 12:30:00
Procedure(s)	Craniotomy	Craniotomy	Craniotomy
	Entry 10	Entry 11	Entry 12
Use Attendee	Seidner RN, Jessica	Russin, Jonathan J.	Zelman, Vladimir
Role Performed	Circulator - Relief	Surgeon - Co-Attending	Anesthesiologist - Attending
me In	12/19/17 12:30:00	12/19/17 11:47:00	12/19/17 07:24:00
me Out	12/19/17 13:00:00	12/19/17 12:43:00	12/19/17 14:49:00
Procedure(s)	Craniotomy	Craniotomy	Craniotomy, Craniotomy
	Entry 13	Entry 14	Entry 15
Use Attendee	Seidner RN, Jessica	Seidner RN, Jessica	Park, Ellen Jiwon
Role Performed	Scrub - Relief	Circulator - Relief	Anesthesiologist - Attending
me In	12/19/17 14:00:00	12/19/17 14:25:00	12/19/17 14:50:00
me Out	12/19/17 14:24:00	12/19/17 14:45:00	12/19/17 17:00:00
Procedure(s)	Craniotomy	Craniotomy	Craniotomy

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	Entry 16	Entry 17
Role Attended	Seidner RN, Jessica	Russin, Jonathan J.
Role Performed	Scrub - Relief	Surgeon - Co-Attending
Time In	12/19/17 15:20:00	12/19/17 14:00:00
Time Out	12/19/17 17:00:00	12/19/17 15:14:00
Procedure(s)	Craniotomy	Craniotomy

**Catheter, Drains, Tub - USC MOR**

**Post-Care Text:**

A.310 Identifies factors associated with an increased risk for hemorrhage or fluid and electrolyte imbalance  
Im.250 Administers care to invasive device sites

**Entry 1**

Device Description	Device Type	Indwelling
CATHETER URETHRAL BARD		
BARDEX IC BACTI-GUARD		
HYDROGEL NATURAL RUBBER		
OD14 FR 5 CC 2 WAY		
FOLEY BALLOON		
ATRAUMATIC INSERTION		
STERILE LATEX DISPOSABLE		
Location	Bladder	Balloon Inflation
Present on Arrival?	No	Amount
End at End of Case?	No	Inserted By
Drainage Details		Rosario RN, Judith
Drainage?	Yes	Amount
Color	Yellow	Measured in Milliliters
Outcome Met (0.60)	Yes	(mL)
		Dependent drainage bag

**Post-Care Text:**

E.340 Evaluates tubes and drains are intact and functioning as planned 0.60 Patient is free from signs and symptoms of injury caused by extraneous objects

**Counts Verification - USC MOR**

**Post-Care Text:**

A.20 Verifies operative procedure, surgical site, and laterality A.20.2 Assesses the risk for unintended retained foreign body Im.20 Performs required counts

**Entry 1**

Procedure	Craniotomy	Items included in the Initial Count	Sponges, Sharps
Initial Counts			
Initial Counts	Sam RN, John, Hunanyan,	Items included in the Initial Count	Sponges, Sharps
Performed By	Arsen		
Initial Count			
Lossing Counts			
Lossing Counts	Sam RN, John, Seidner	Items included in the Closing Count	Sponges, Sharps
Performed By	RN, Jessica		
Final Counts			
Final Count Status	Incorrect	Did you use Radio Frequency Wanding for this case?	No
Final Counts	Seidner RN, Jessica,	Items Included in Final Count	Sponges, Sharps
Performed By	Sam RN, John		
Outcome Met (0.20)	No		

**Post-Care Text:**

E.50 Evaluates results of the surgical count 0.20 Patient is free from unintended retained foreign objects

**Counts Actions Taken - USC MOR**

**Entry 1**

(Continued)

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Surgeon Notified	Yes	X-Ray of Surgical Site Obtained?	Yes
X-Ray Result?	Negative	Read by Radiologist/Attending Surgeon:	Balakrishnan, Sudheer

**General Comments:**

DR. KRAMER SPOKE TO RADIOLOGY REGARDING NEGATIVE RESULTS.

**Patient Positioning - USC MOR**

**Pre-Care Text:**

A.240 Assesses baseline skin condition A.280 Identifies baseline musculoskeletal status A.280.1 Identifies physical alterations that require additional precautions for procedure-specific positioning A.510.8 Maintains patient's dignity and privacy Im.120 Implements protective measures to prevent skin/tissue injury due to mechanical sources Im.40 Positions the patient Im.80 Applies safety devices

**Entry 1**

Procedure	Craniotomy	Body Position	Supine
Left Arm Position	Tucked and padded at side	Right Arm Position	Tucked and padded at side
Left Leg Position	Extended	Right Leg Position	Extended
Leg Uncrossed?	Yes	Pressure Points Checked	Yes
Positioning Device	Head Protector, Elbow Protector, Strap - Safety, Table - Standard	Positioned By	Lee, Justin C., Sam RN, John, Rosario RN, Judith, Lee, Jessica
Safety Strap Applied?	Yes	Location	Chest
Outcome Met (0.80)	Yes		

**Post-Care Text:**

E.10 Evaluates for signs and symptoms of physical injury to skin and tissue E.290 Evaluates musculoskeletal status 0.80 Patient is free from signs and symptoms of injury related to positioning

**Assessment of Body - USC MOR**

**Entry 1**

**Entry 2**

Date/Time Checked	12/19/17 11:23:00	12/19/17 14:30:00
Site	Arm, left, Arm, right, Torso, Leg, left, Leg, right	Arm, left, Arm, right, Torso, Leg, left, Leg, right

**General Comments:**

BUE AND BLE WARM TO TOUCH WITH PULSES PAPABLE, BODY IN CORRECT SURGICAL POSITION AND ALIGNMENT.

**Skin Prep - USC MOR**

**Pre-Care Text:**

A.30 Verifies allergies A.20 Verifies procedure, surgical site, and laterality A.510.8 Maintains patient's dignity and privacy Im.270 Performs Skin Preparation Im.270.1 Implements protective measures to prevent skin and tissue injury due to chemical sources A.300.1 Protects from cross-contamination

**Entry 1**

Skin Prep		Prep By	Lee, Justin C.
Prep Agents (Im.270)	Iodine Povacrylex and Isopropyl Alcohol	Prep Area Details	Left
Prep Area (Im.270)	Head		
Skin Prep Agent Dry	Yes		
Without Pooling			
Hair Removal			
Hair Removal Methods	Clipper	Hair Removal By	Lee, Justin C.
Hair Removal Site	Head	Hair Removal Site Details	Left
Outcome Met (0.100)	Yes		

**Post-Care Text:**

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E.10 Evaluates for signs and symptoms of physical injury to skin and tissue O.100 Patient is free from signs and symptoms of chemical injury

**General Case Data - USC MOR**

**Pre-Care Text:**

A.350.1 Classifies surgical wound  
**Entry 1**

**Case Information**

MR	USC OR 07	Case Level	5
Wound Class	1-Clean	Specialty	Neurosurgery (SN)
ASA Class	3		
Prep Diagnosis	Epilepsy, unspecified		

**Post-Care Text:**

O.760 Patient receives consistent and comparable care regardless of the setting

**Implant Log - USC MOR**

**Pre-Care Text:**

A.20 Verifies operative procedure, surgical site, and laterality A.20.1 Verifies consent for planned procedure  
Im.350 Records implants inserted during the operative or invasive procedure

	<b>Entry 1</b>	<b>Entry 2</b>	<b>Entry 3</b>
Implant/Explant	Implant	Implant	Implant
Implant			
Identification			
Description	GRAFT SOFT TISSUE 3X3IN DURAGEN CRANUM BOVINE COLLAGEN MATRIX PATCH RESORBABLE	COVER BURR HOLE MEDPOR TITANIUM LOW PROFILE OD7 MM TAB STERILE	PLATE BONE UNIVERSAL NEURO III SMALL BOX LOW PROFILE CRANIOMAXILLOFACIAL 2 X 2 HOLE 1.5 MM SCREW
Size	3X3		
Serial Number	1172609		
Lot Number			
Manufacturer	INTEGRA LIFE SCIENCES	STRYKER ORTHOPAEDICS	STRYKER
Catalog #	DURS3391	5334507	53-34228
Expiration Date	07/31/19		
Usage Data			
Implant Site	Scalp	Scalp	Scalp
Select Left or Right when Applicable:	Left	Left	Left
Quantity	1	1	1
Outcome Met (0.30)	Yes	Yes	Yes
	<b>Entry 4</b>	<b>Entry 5</b>	
Implant/Explant	Implant	Implant	
Implant			
Identification			
Description	PLATE BONE UNIVERSAL NEURO III DOG LOW PROFILE L16 MM CRANIOMAXILLOFACIAL 2 HOLE BAR 1.5 MM SCREW	SCREW BONE UN3 L4 MM OD1.5 MM CRANIOMAXILLOFACIAL SELF DRILL	
Size			
Serial Number			
Lot Number			
Manufacturer	STRYKER	STRYKER	
Catalog #	53-34216	56-15904	
Expiration Date			
Usage Data			
Implant Site	Scalp	Scalp	
Select Left or Right when	Left	Left	



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licable)  
ite Sterilized  
Comments  
Outcome Met (0.700) Yes Yes Yes

**Post-Care Text:**  
E.10 Evaluates signs and symptoms of physical injury to skin and tissue 0.700 Patient is free from signs and symptoms of injury caused by extraneous objects

**Suturing - USC MOR**  
**Pre-Care Text:**  
A.240 Assesses baseline skin condition A280.1 Identifies baseline musculoskeletal status Im.50 Implements protective measures to prevent injury due to electrical sources Im.60 Uses supplies and equipment within safe parameters Im.80 Applies safety devices

**Entry 1**

SU Type	Electrosurgical Unit	Identification Number	F1F18042A
SU Settings			
Bipolar Setting	35	Coag Setting	35
Autotransformer Setting	35		
Grounding Pad			
Details			
Grounding Pad Needed?	Yes	Grounding Pad Lot Number	72210153X EXP 2019-08-23
Within Expiration Date?	Yes	Grounding Pad Site	Thigh
Grounding Pad Site	Right	Hair Removed Under Grounding Pad	No
Detail		Verified By	Sam RN, John
Skin Condition Under Grounding Pad	Intact		
Smoke Evacuation Device Used	No	Outcome Met (0.10)	Yes

**Post-Care Text:**  
E.10 Evaluates for signs and symptoms of physical injury to skin and tissue 0.10 Patient is free from signs and symptoms of injury related to thermal sources

**Cultures and Specimen - USC MOR**  
**Pre-Care Text:**  
A.20 Verifies operative procedure, surgical site, and laterality Im.320 Manages culture specimen collection  
Im.330 Manages specimen handling and disposition

**Entry 1**

Cultures Ordered	No	Specimens Ordered	Yes
Outcome Met (0.40)	Yes		

**Post-Care Text:**  
E.40 Evaluates correct processes have been performed for specimen handling and disposition 0.40 Patient's specimen(s) is managed in the appropriate manner

**General Comments:**  
ROUTINE: LEFT HIPPOCAMPUS (PARTIAL HIPPOCAMPUS SENT FOR STUDY)

**Washing/Packing - USC MOR**  
**Pre-Care Text:**  
A.350 Assesses susceptibility for infection Im.250 Administers care to invasive devices Im.290 Administer care to wound sites Im.300 Implements aseptic technique

**Entry 1**

Wash Prep Agent	NA
Moved Prior to Washing?	
Washing Item	
Details	
Washing Item	Other: See comments
(Im.290)	

ited by:  
ited on:

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Site  
Outcome Met (0.200) Scalp Site Details Left  
Yes

**Post-Care Text:**

E.320 Evaluate factors associated with increased risk for postoperative infection at the completion of the procedure 0.200 Patient's wound perfusion is consistent with or improved from baseline levels

**General Comments:**

ABX OINT AND ISLAND DRESSING PLACED AT INCISION SITE.

**Communication - USC MOR**

**Entry 1**

Communication Patient Flow/Bed Control Communication By Sam RN, John  
Date and Time 12/19/17 09:20:00

**General Comments:**

POST OP ICU BED 4C150

**Skin Assessment - USC MOR**

**Post-Care Text:**

A.240 Assesses baseline skin condition Im.120 Implements protective measures to prevent skin or tissue injury due to mechanical sources Im.280.1 Implements protective measures to prevent skin or tissue injury due to thermal sources Im.360 Monitors for signs and symptoms of infection

**Entry 1**

Skin Integrity Intact Outcome Met (0.60) Yes

**Post-Care Text:**

E.10 Evaluates for signs and symptoms of physical injury to skin and tissue E.270 Evaluate tissue perfusion  
0.60 Patient is free from signs and symptoms of injury caused by extraneous objects

**Safety Checklist 3) Sign Out - USC MOR**

**Post-Care Text:**

Im.330 Manages specimen handling and disposition

**Entry 1**

Use verbally confirms with team the name of the operative procedure(s) and correct CPT code	Yes	Nurse verbally confirms with team specimen identity and label	Yes
Use verbally confirms with team key equipment problems to be addressed	NA	The nurse confirmed with the surgeon and the incision is:	Left Open
Are the instrument, sponge, and needle counts correct?	No	All team members review key concerns for recovery and management of patient	Yes
Is this case a trauma case? Is an implant used in this case?	No	Was this an endoscopic case?	No

**Post-Care Text:**

E.800 Ensures continuity of care E.50 Evaluates results of the surgical count

**Departure from OR - USC MOR**

**Entry 1**

Patient Handoff Drowsy  
Status  
Transfer Evaluation

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<b>Assessment</b>	ESU Pad Site Checked, Warm Blanket Applied, Pressure Areas Checked, Sterile Dressing Intact	<b>Skin Condition</b>	Warm, Dry
<b>Patient Handoff Status</b>	Extubated	<b>Oxygen in Use?</b>	Yes
<b>Flow Rate</b>	6 L/min	<b>Airway Device</b>	Nasal Cannula or Mask
<b>Patient IV Access</b>	Yes	<b>Post-op Destination</b>	ICU
<b>Patient Position</b>	Bed		
<b>Discharge Report Given By</b>	Sam RN, John	<b>Time Discharged/Transferred</b>	12/19/17 17:00:00

**General Comments:**  
REPORT GIVEN TO ICU RN DEBBIE WITH ALL QUESTIONS ANSWERED.

**Use Comments**

<None>

Finalized By: Sam RN, John

**Document Signatures**

**Signed By:**

Sam RN, John 12/19/17 17:13

# **Exhibit 42**

Intraoperative Note  
\* Final Report \*



**\* Final Report \***

**Procedure Date:** 1/6/2017

**Study #:** LAC 17-004

**Referring Physician:** Martin Pham, M.D.

**Technician:** MV

**OR#:** 7

**Patient History:** 59 yo F with hx of recurrent stage IV papillary serous ovarian cancer status post hysterectomy and BSO 2007, with recurrence in 2014 s/p chemotherapy. s/p right craniotomy for stealth guided biopsy and resection of R basal ganglia on 4/28/16 s/p gamma knife in May 2016 presenting with worsening headaches and left sided weakness 2/2 to interval growth and edema of R BG mass

**Surgical Procedure:** Right craniotomy for tumor resection

**MONITORING MODALITIES:**

SSEPs (somatosensory evoked potentials) and TcMEPs (transcranial motor evoked potentials).

**RESULTS:**

During the procedure the aforementioned modalities were continuously monitored.

The surgeon was informed at baseline that the patient's potentials amplitudes were adequate for monitoring bilaterally. Post resection the left upper and lower extremity motor evoked potentials were severely decreased in amplitude. 3.5 hours were spent monitoring, and the surgeons were kept informed of the monitoring status and any significant changes.

**IMPRESSION:**

Somatosensory evoked potentials and Transcranial Motor evoked potentials were continuously monitored during surgery. Post resection left upper and lower extremity motor evoked potentials were approx. 90% decreased from baseline and did not recover at closing.

Please see comment.

**COMMENT:** The changes seen in the left upper and lower extremity motor evoked potentials during tumor resection suggest that an interruption of this pathway occurred. Clinical correlation is strongly advised.

Further monitoring data is available by contacting the Intraoperative Neurophysiological Monitoring department

**Signature Line**

Electronically Signed on 01/06/17 15:25 PST

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Vesely, Michael

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The skin was sharply opened with a 10 blade and monopolar electrocautery was used to carry the dissection down to the skull. This was subsequently reflected forward. The prior craniotomy site was identified and the prior Stryker plating system was removed. The bone flap was then subsequently carefully removed from the prior dural scar and saved. The dural opening was subsequently identified and re-opened. What appeared to be the prior surgical corridor covered with arachnoid and encephalomalacic scar was identified. This was confirmed on the Stealth navigation system as the prior X corridor. With the use of the Stealth navigation system, this prior corridor was re-opened with bipolar forceps and suction. The metastasis was subsequently identified at the floor of the surgical corridor. A combination of bipolar forceps, bipolar electrocautery, and the CUSA was used to fully resect what could be seen of the metastasis. Motors were checked about roughly 80% of how we felt the resection was completed and at that time, the motors were normal as compared to preoperatively. Upon continued resection, there was noted to be significant decrease in motor signals with a decline of roughly 80% to 90%. At this point, it was felt that the surgery had progressed near enough to either the internal capsule or the projections of the motor cortex and so the decision was made to halt resection at that time in case there had been some iatrogenic injury to her motor function. Meticulous hemostasis and irrigation was subsequently achieved. A monolayer of Surgicel was placed within the resection cavity. The dura was then reapproximated with interrupted 4-0 Nurolon and the epidural space was again irrigated and meticulously hemostased. DuraGen was cut to size, laid over the durotomy. The bone was then plated back with a Stryker plating system. The field was again irrigated and meticulous hemostased. The galeal layers were then reapproximated using inverted interrupted 2-0 Vicryl sutures. The skin edges were then reapproximated with 4-0 Monocryl stitch. The incision was dressed with antibiotic ointment. Drapes were then taken down. The patient's head was removed from the Mayfield skull clamp. She was then extubated and taken to the intensive care unit for further monitoring and care. All sponge and needle counts were correct at the end of the procedure. Again, neurophysiologic monitoring using SSEP was stable; however, as noted within the intraoperative report, MEPs were significantly down on the left body, roughly 80% to 90% at the conclusion of the operation.

The patient's condition otherwise at the conclusion of the operation was stable.

Dictated By: Martin Huy Pham

Gene Y Sung, MD

MHP/MODL

JOB #: A large black rectangular redaction box with a white 'X' drawn through it, indicating a signature has been removed.

**Signature Line**

Electronically Signed on 04/13/17 14:20 PDT

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Pham, Martin Huy, MD

Electronically Signed on 02/07/17 06:46 PST

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Sung, Gene Y., MD

neurosurgery Inpatient Progress Note

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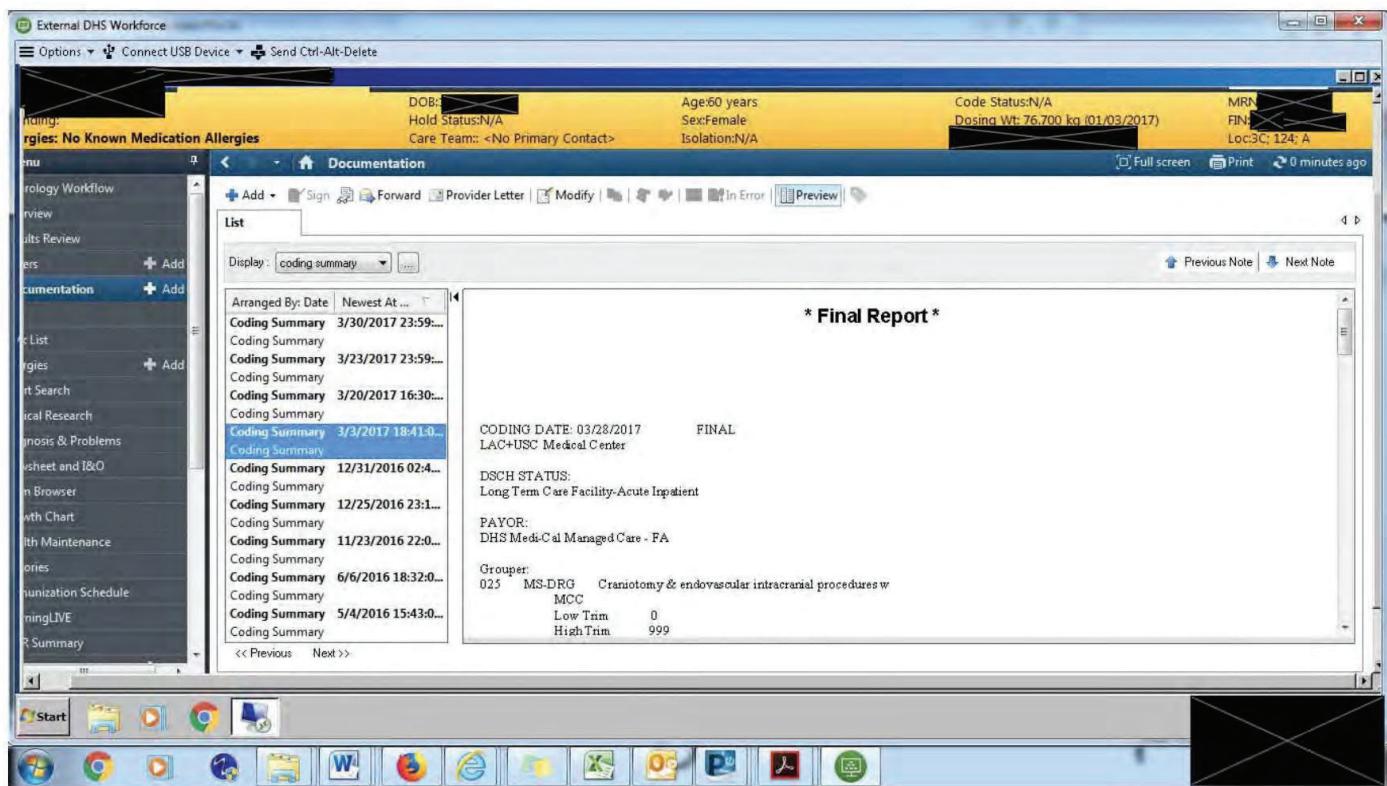
**acetaminophen-HYDROcodone 325 mg-10 mg Tab** 1 tabs, Oral, Q6H-INT  
**acetaminophen-HYDROcodone 325 mg-5 mg Tab** 1 tabs, Oral, Q6H-INT  
**dextrose 50% INJ Syringe 50 mL** 25 mL, IV Push, Q15MIN-INT  
**dextrose 50% INJ Syringe 50 mL** 50 mL, IV Push, Q15MIN-INT  
**glucagon 1 mg INJ PWVL** 1 mg, Intramuscular, Q15MIN-INT  
**hydrALAZINE 20 mg/mL INJ 1 mL** 10 mg 0.5 mL, IV Push, Q10MIN-INT  
**labetalol 5 mg/mL INJ Syringe 4 mL** 10 mg 2 mL, IV Push, Q10MIN-INT  
**morphine 4 mg/1 mL INJ Syringe** 2 mg 0.5 mL, IV Push, Q2H-INT  
**ondansetron 2 mg/mL INJ 2 mL** 4 mg 2 mL, IV Push, Q6H-INT  
**senna 8.6 mg Tab** 17.2 mg 2 tabs, Oral, ONCE

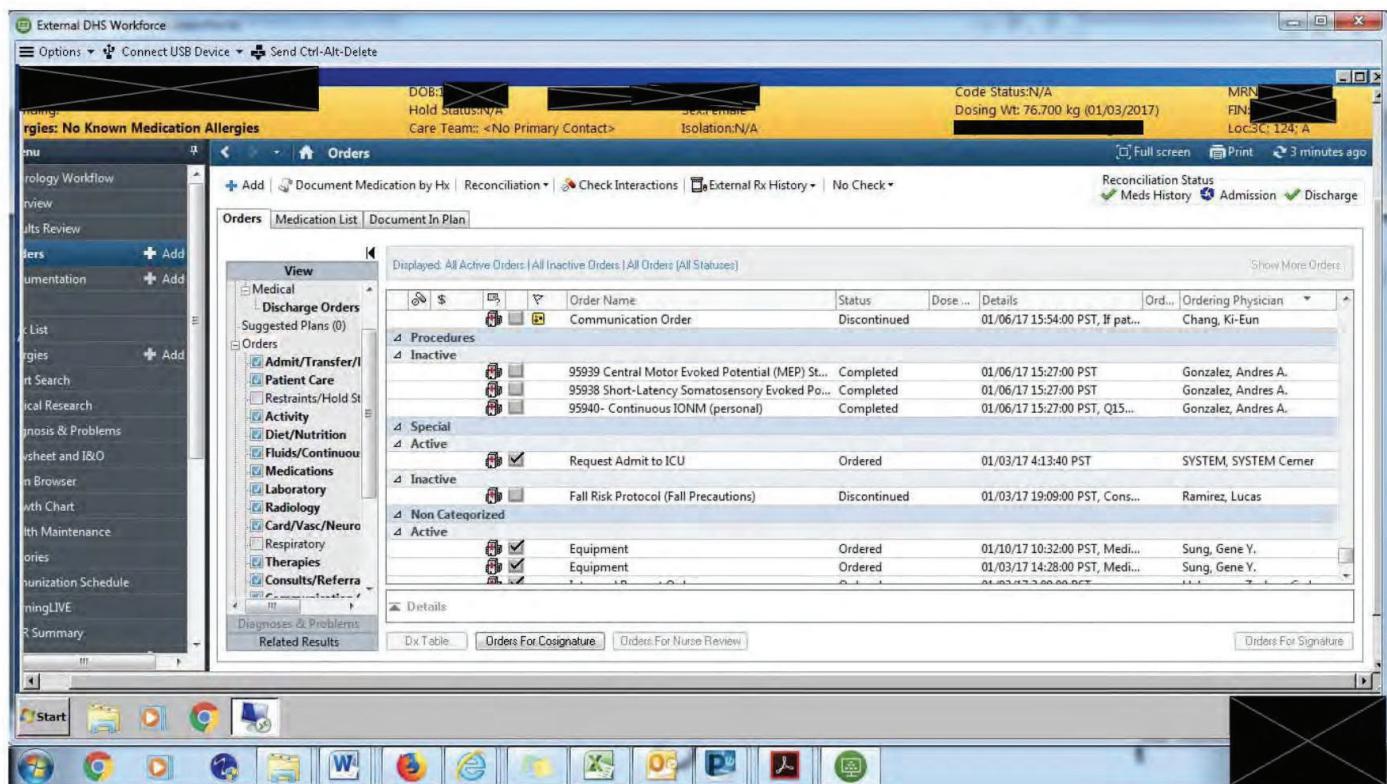
**Physical exam:**

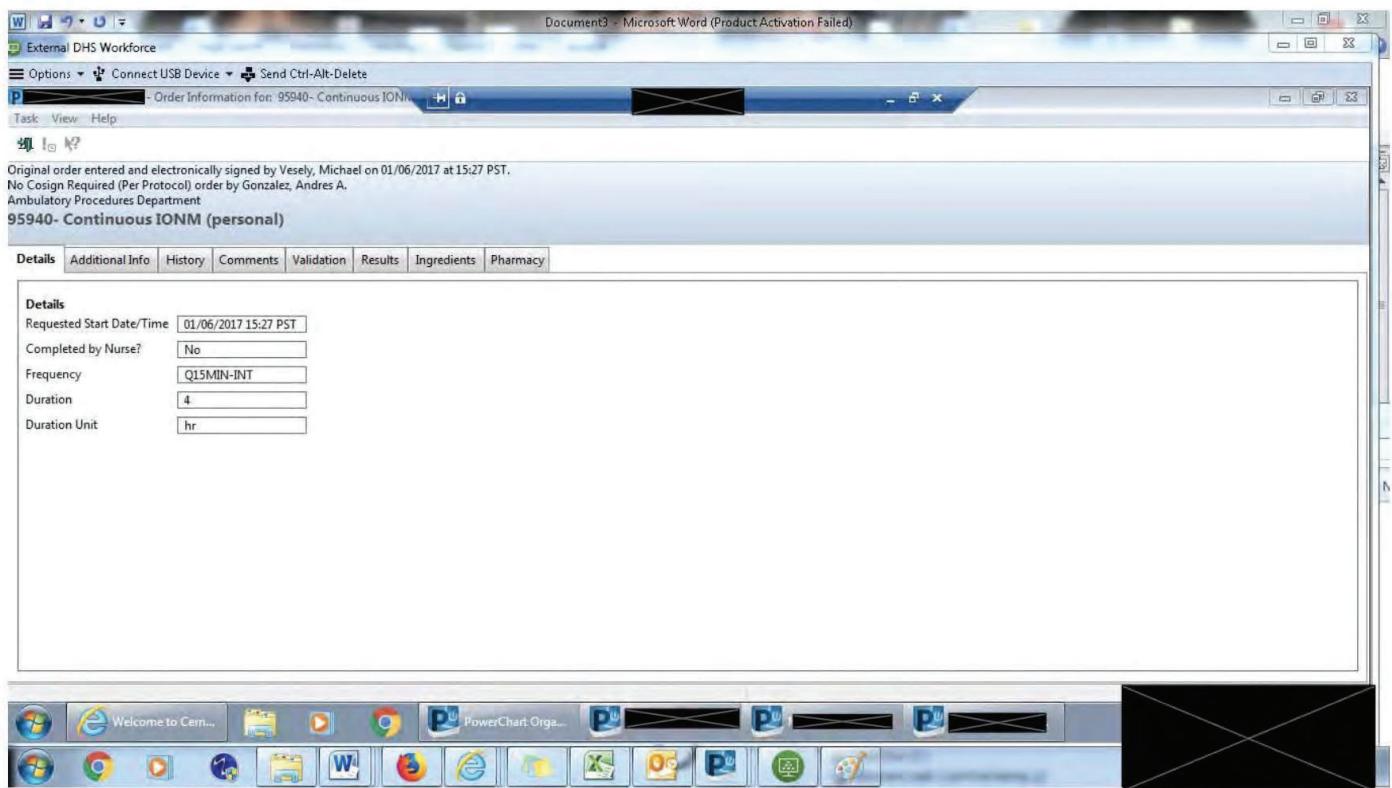
E4M6V5, c/o of moderate pain  
A&Ox4, NAD, sleeping in bed comfortably, breathing room air.  
EOMI, PERRL

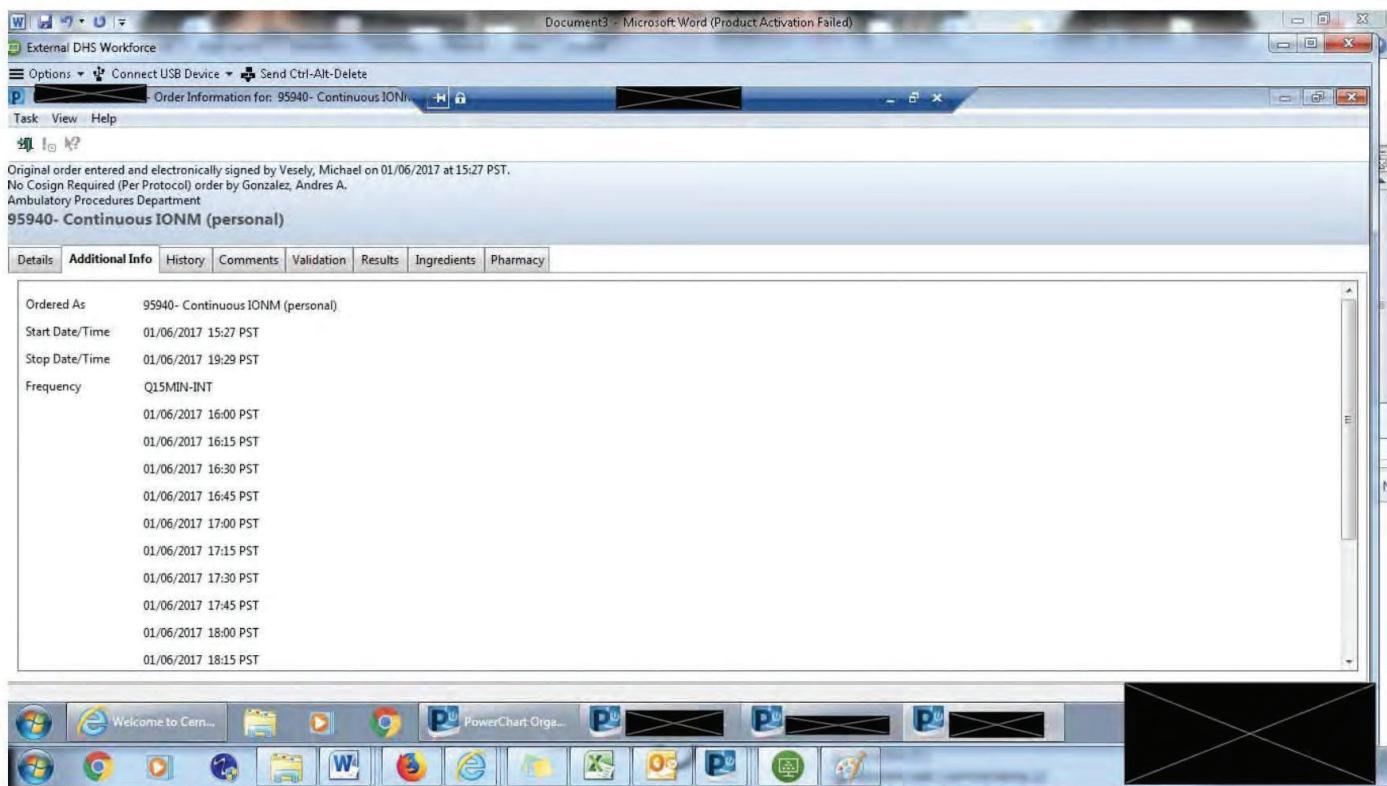
**LUE and LLE no movement**

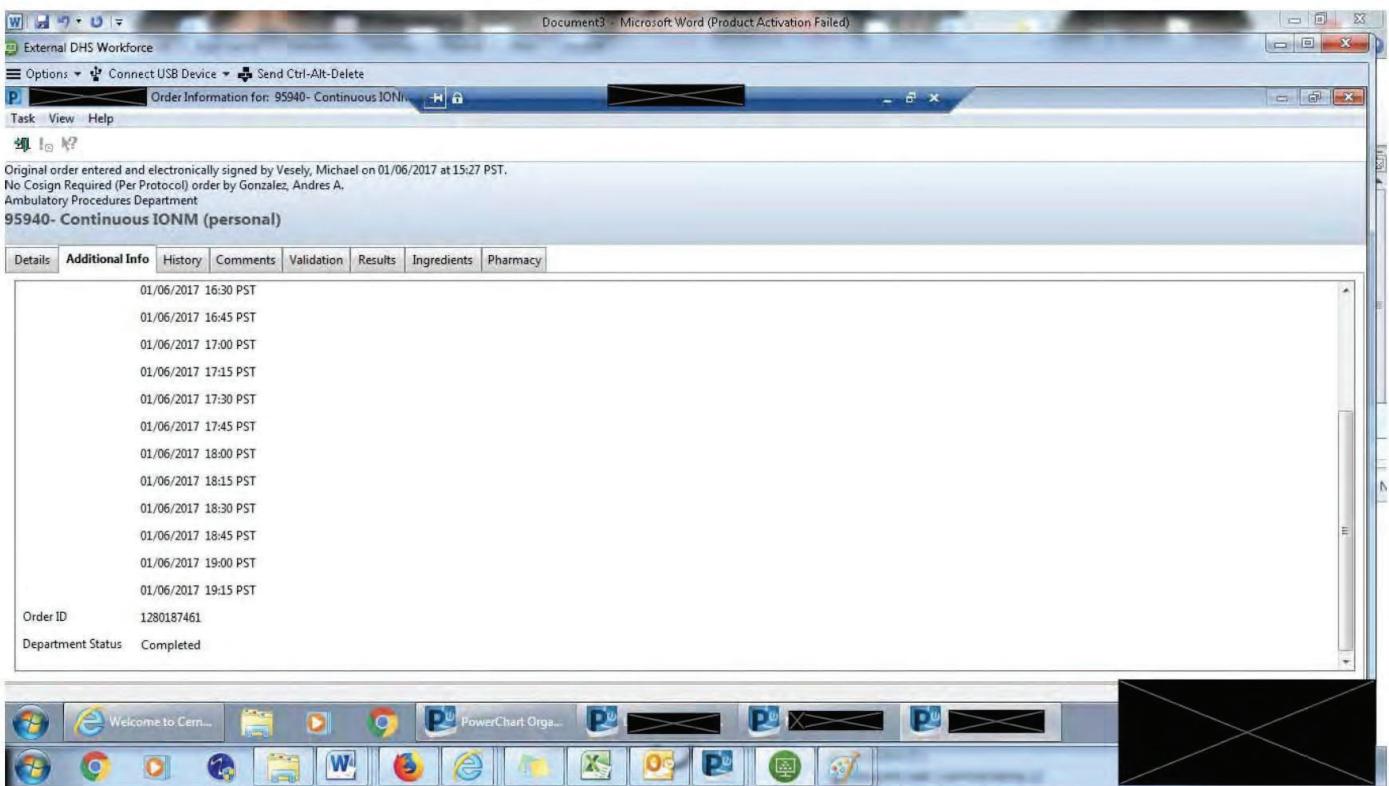
RUE and LLE moves to commands  
Wound c/d/l

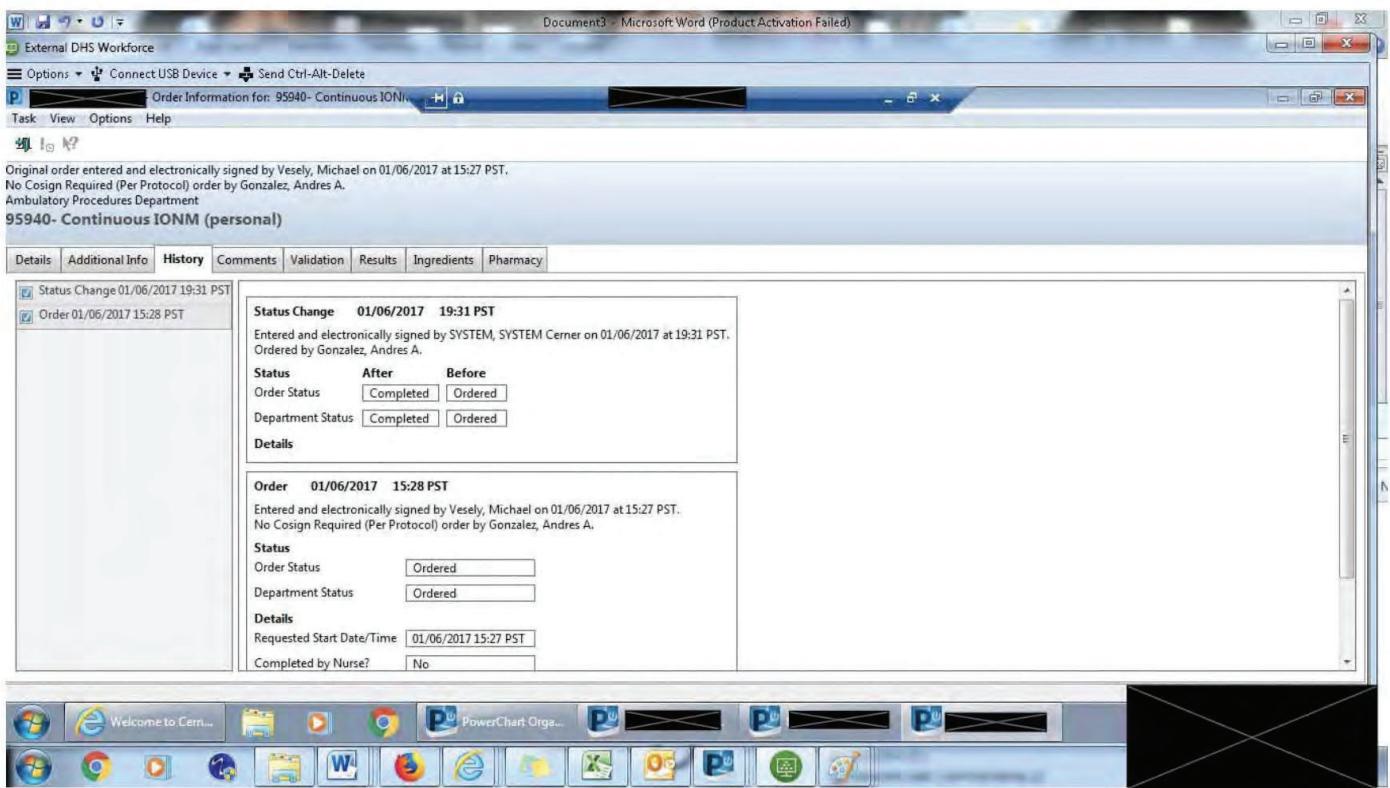


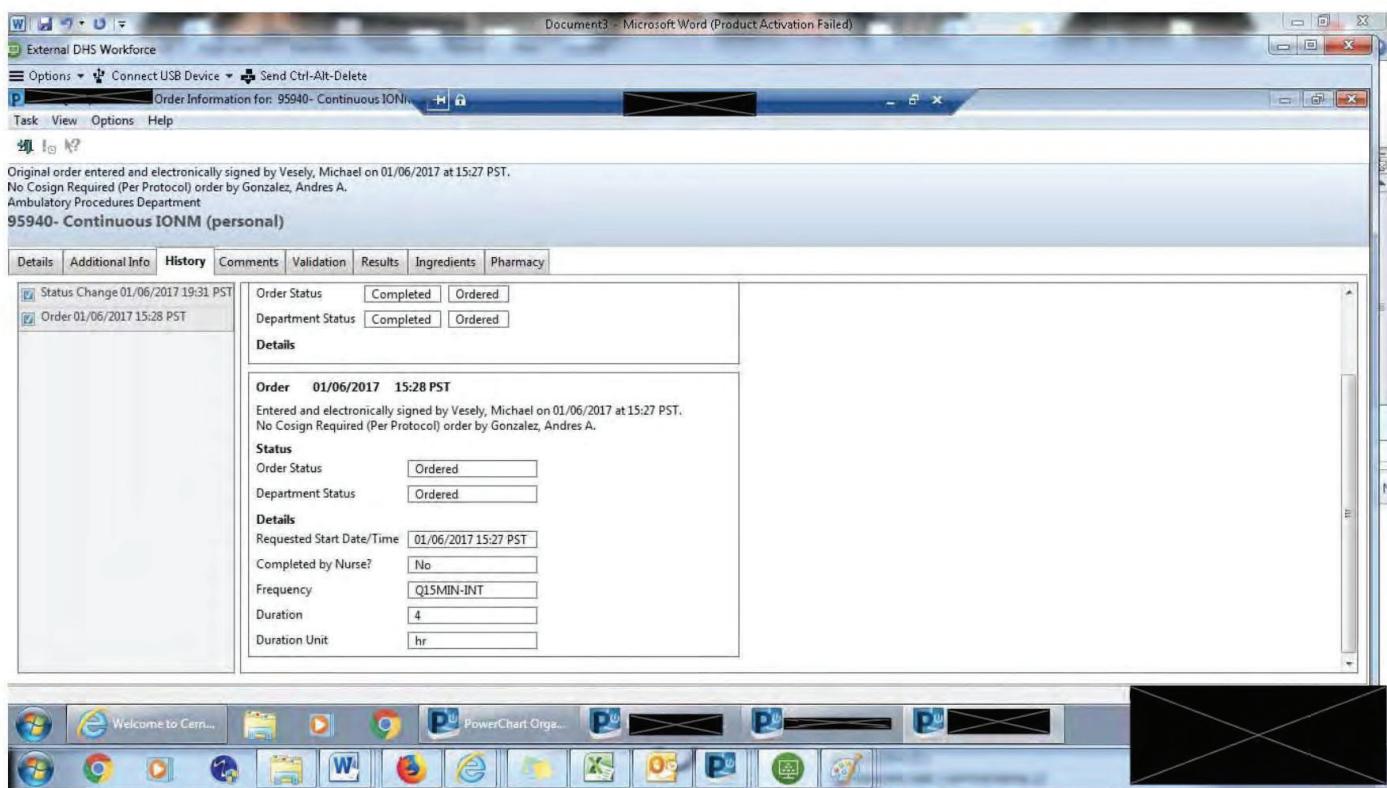


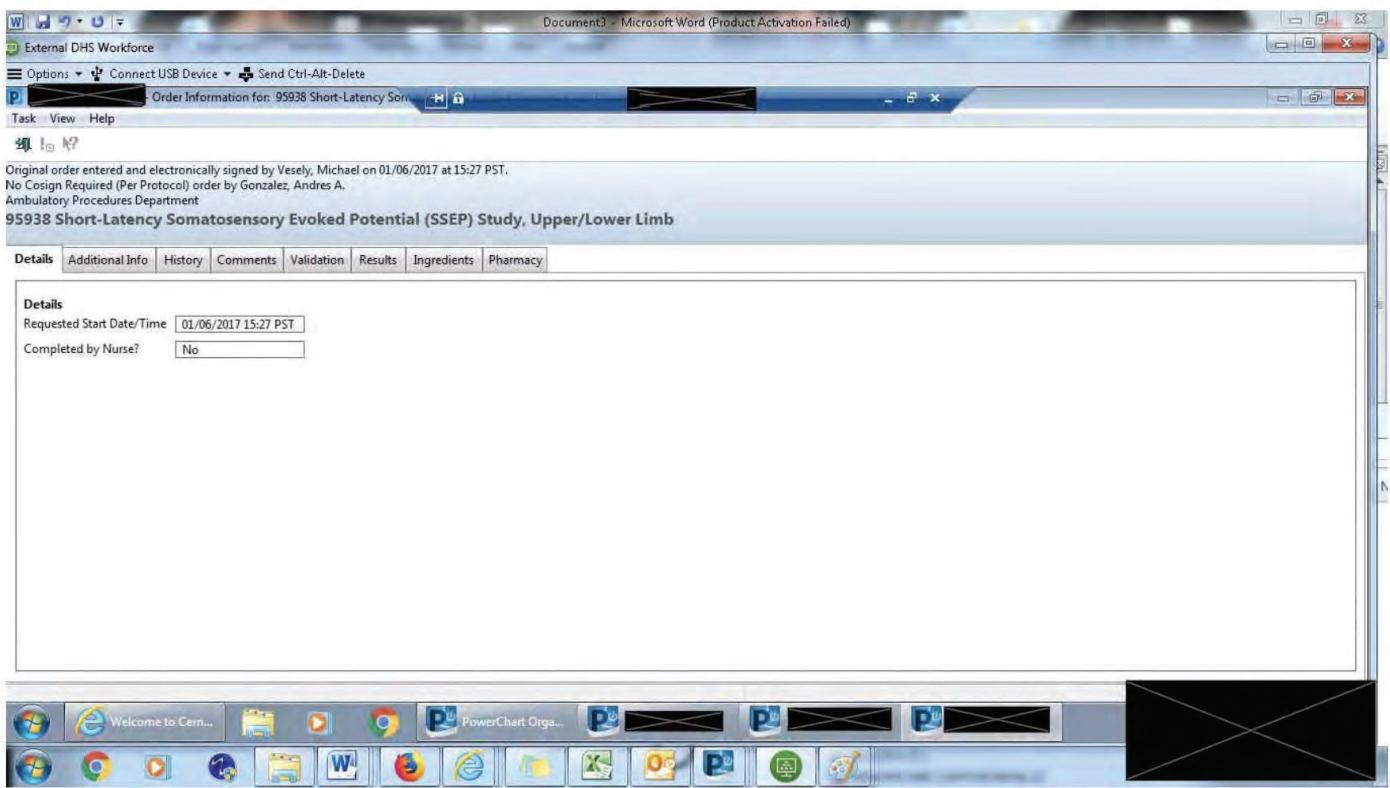


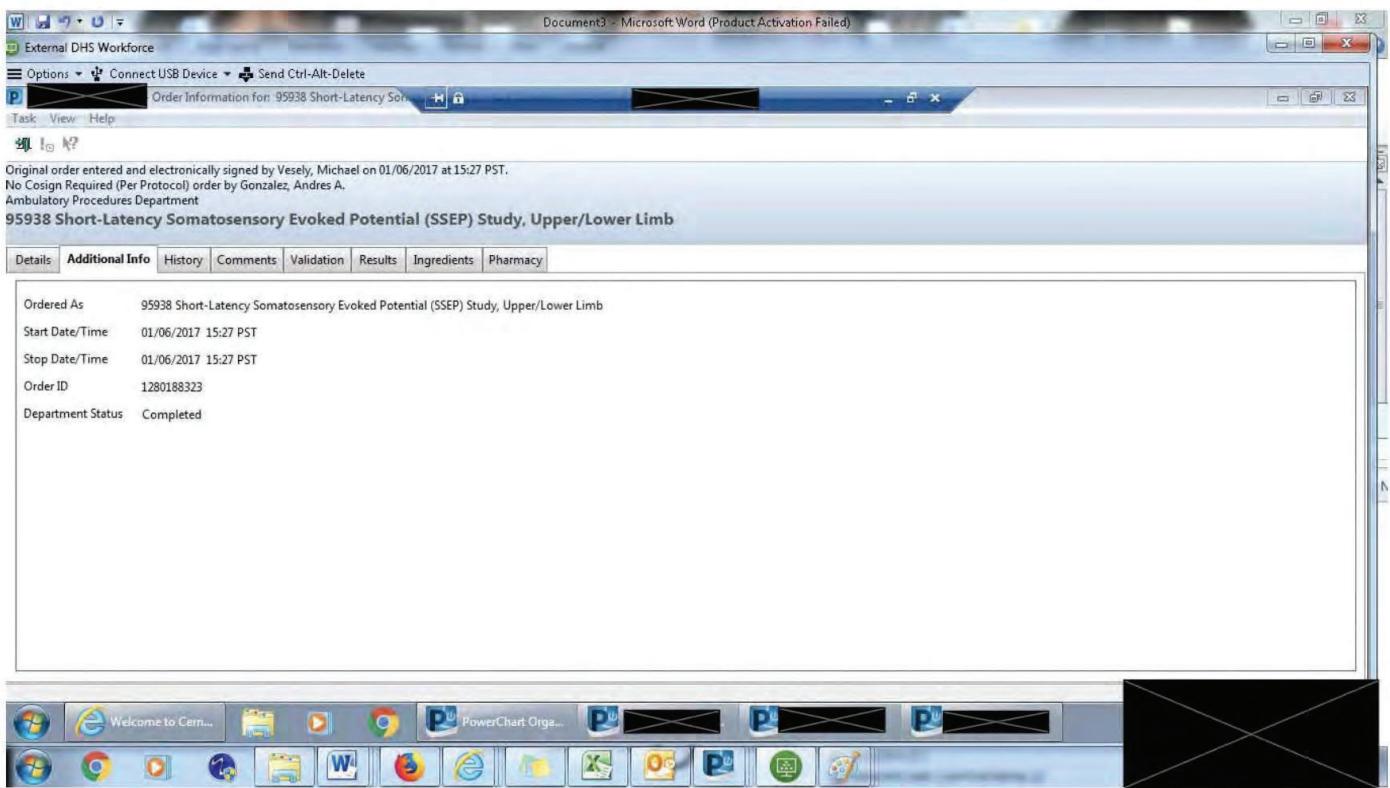


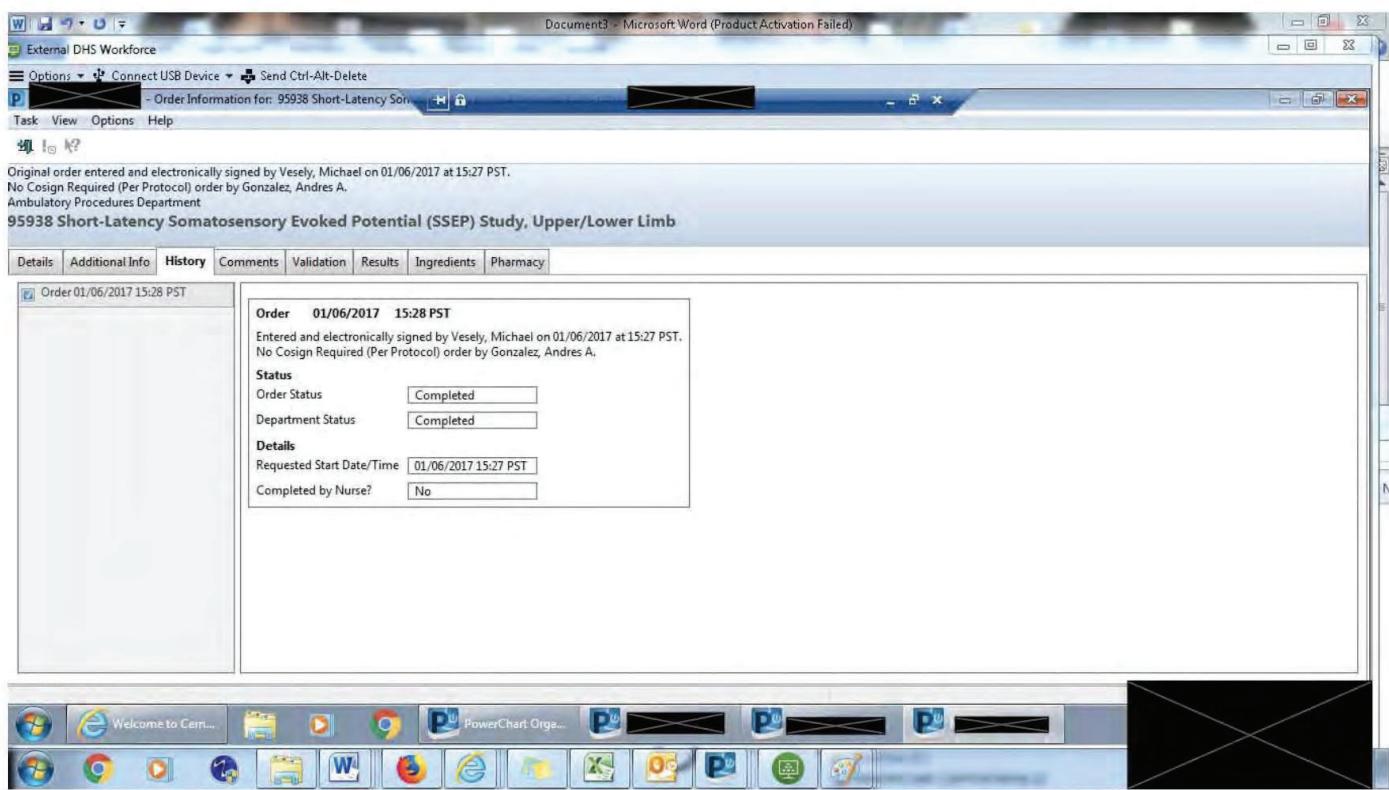


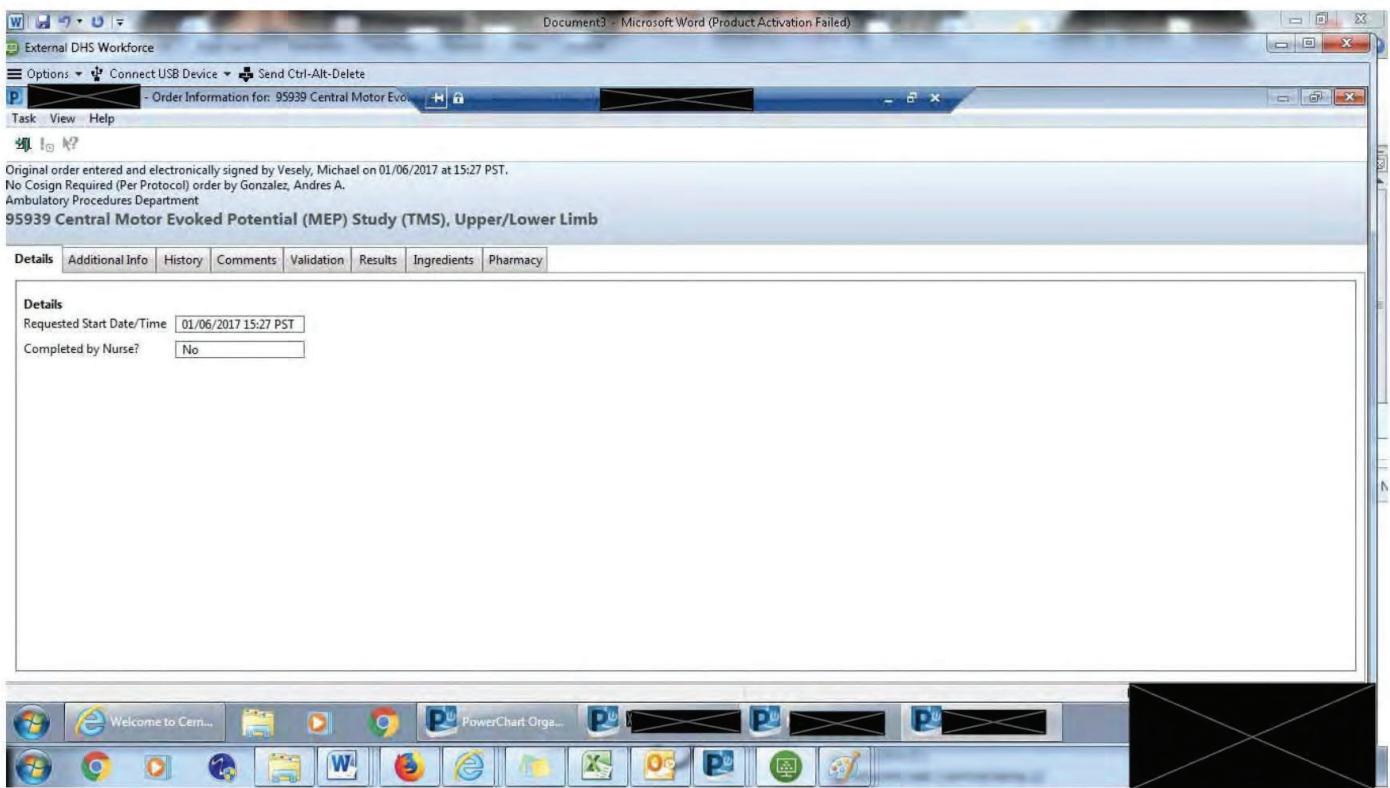


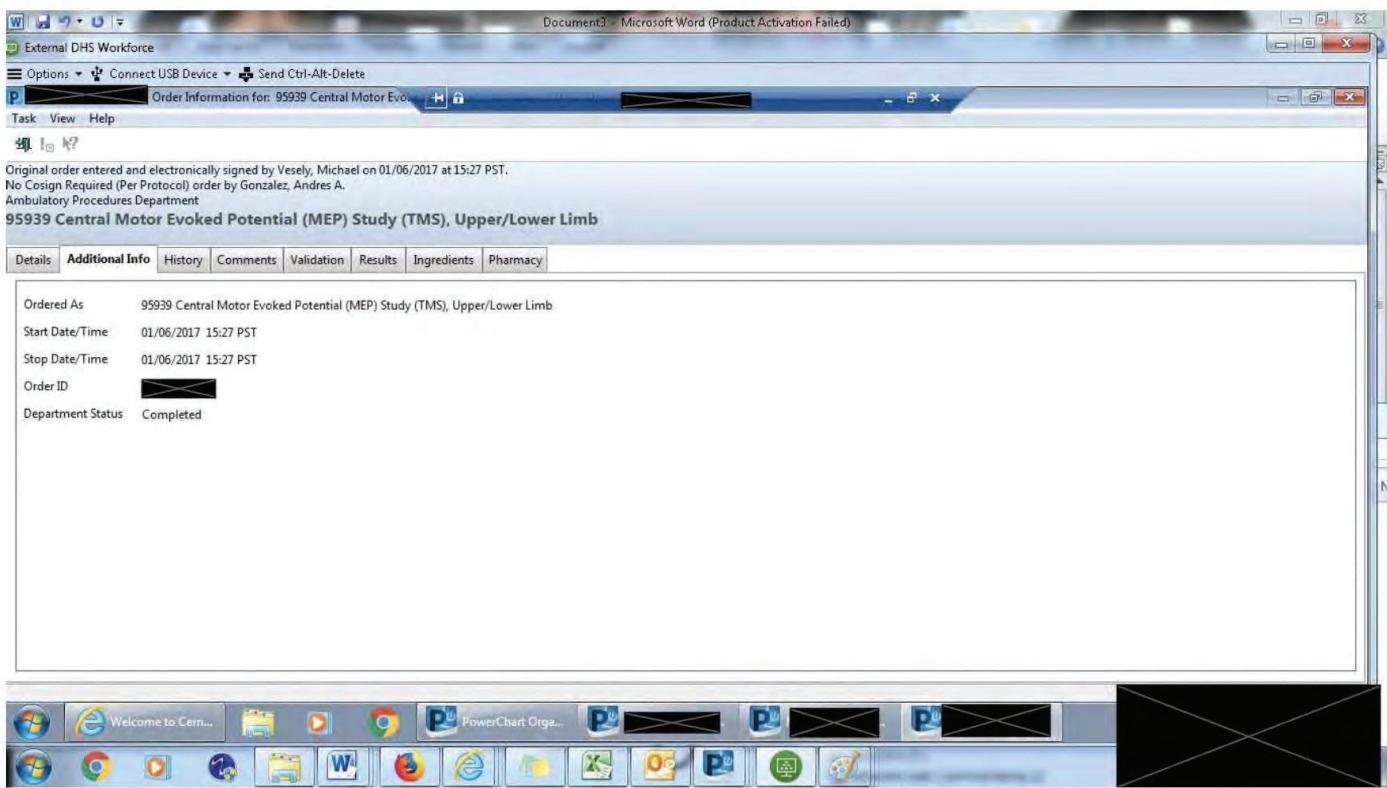


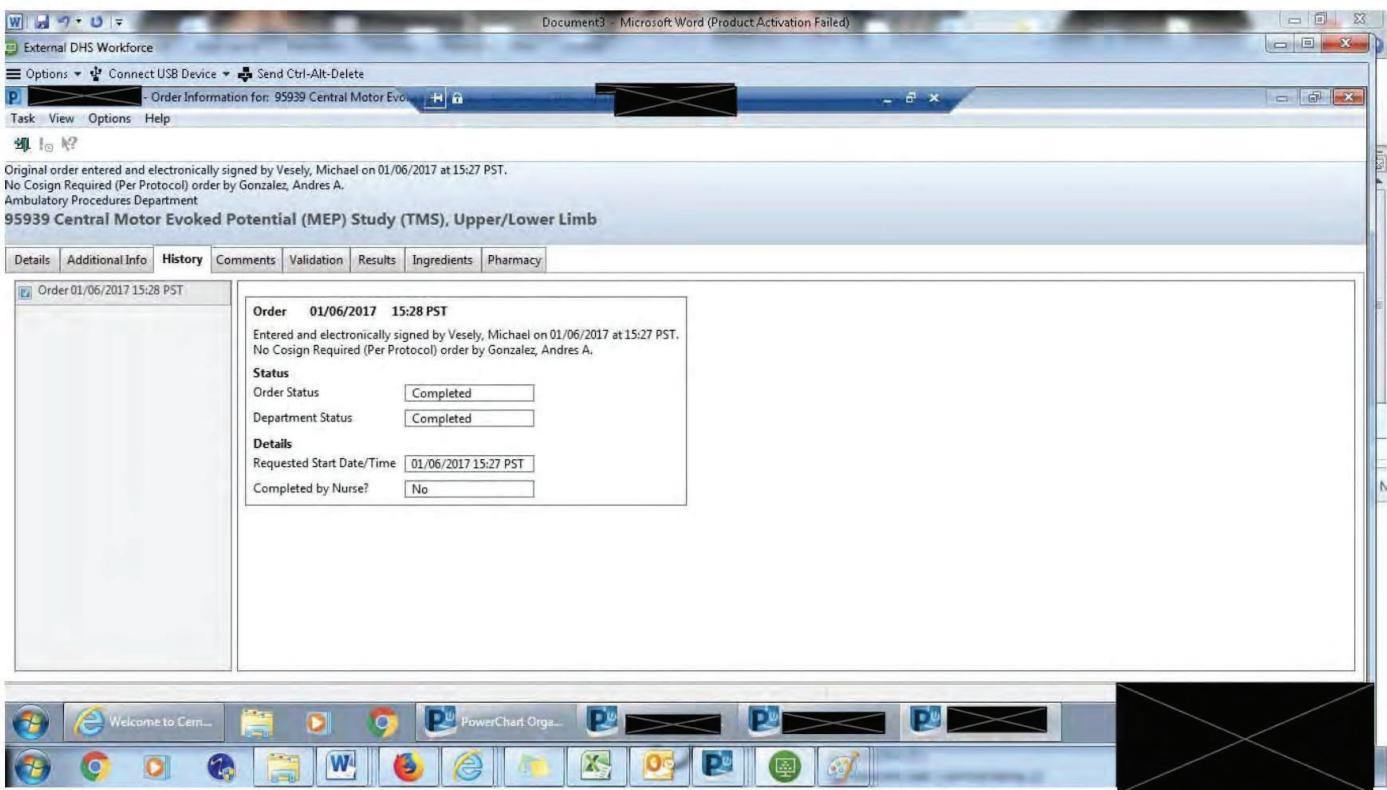












1 AG  
FJ

Intraoperative Note  
\* Final Report \*



**\* Final Report \***

**Procedure Date:** 1/6/2017

**Study #:** LAC 17-004

**Referring Physician:** Martin Pham, M.D.

**Technician:** MV

**OR#:** 7

**Patient History:** 59 yo F with hx of recurrent stage IV papillary serous ovarian cancer status post hysterectomy and BSO 2007, with recurrence in 2014 s/p chemotherapy. s/p right craniotomy for stealth guided biopsy and resection of R basal ganglia on 4/28/16 s/p gamma knife in May 2016 presenting with worsening headaches and left sided weakness 2/2 to interval growth and edema of R BG mass

**Surgical Procedure:** Right craniotomy for tumor resection

**MONITORING MODALITIES:**

SSEPs (somatosensory evoked potentials) and TcMEPs (transcranial motor evoked potentials).

**RESULTS:**

During the procedure the aforementioned modalities were continuously monitored.

The surgeon was informed at baseline that the patient's potentials amplitudes were adequate for monitoring bilaterally. Post resection the left upper and lower extremity motor evoked potentials were severely decreased in amplitude. 3.5 hours were spent monitoring, and the surgeons were kept informed of the monitoring status and any significant changes.

**IMPRESSION:**

Somatosensory evoked potentials and Transcranial Motor evoked potentials were continuously monitored during surgery. Post resection left upper and lower extremity motor evoked potentials were approx. 90% decreased from baseline and did not recover at closing.

Please see comment.

**COMMENT:** The changes seen in the left upper and lower extremity motor evoked potentials during tumor resection suggest that an interruption of this pathway occurred. Clinical correlation is strongly advised.

Further monitoring data is available by contacting the Intraoperative Neurophysiological Monitoring department

**Signature Line**

Electronically Signed on 01/06/17 15:25 PST

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Vesely, Michael

Intraoperative Note  
\* Final Report \*

Operative Report  
\* Final Report \*

**\* Final Report \***

**Operative Report**

REPORT OF OPERATION

DEPARTMENT: NEUROLOGY-PY DATE OF OPERATION: January 06, 2017

ATTENDING SURGEON: Gene Y Sung, MD

DICTATED BY: Martin Huy Pham

OPERATING SURGEON: Martin Huy Pham

ASSISTANT(S): Ki Chang, MD.

PREOPERATIVE DIAGNOSIS: Recurrent right-sided frontal ovarian metastasis.

POSTOPERATIVE DIAGNOSIS: Recurrent right-sided frontal ovarian metastasis.

PROCEDURE PERFORMED: Redo right-sided craniotomy for resection of metastasis.

ANESTHESIA: General.

COMPLICATIONS: None.

MONITORING: Neurophysiologic monitoring with SSEP and MEP.

IMPLANTS USED: Stryker plating system.

INDICATIONS FOR PROCEDURE: This is a 59-year-old female with a known history of metastatic ovarian cancer. She had a history of a prior right-sided craniotomy for resection of a right-sided ovarian metastasis earlier this year around April of 2016. Over time it was shown that the residual from her prior resection cavity had progressed causing a significant amount of edema. Therefore, she was offered re-resection of this residual metastasis. The risks, benefits, alternatives associated with the surgery were discussed in detail with the patient. The risks included, but were not limited, to infection, bleeding, brain injury, hemiparesis, stroke, and coma. Specifically to this operation, due to the location of the metastasis near both the internal capsule as well as the corona radiata of the motor cortex, she and her family also understood the very real possibility of postoperative hemiparesis or hemiplegia due to the location of the tumor. Medical complications included heart attack, stroke, DVT, PE, pneumonia, possibly death. Despite the risks of the surgery, she wished to and consented to proceed with operative intervention.

PROCEDURE: The patient was brought back to the operating room. She underwent endotracheal intubation with induction of general anesthesia without any complications. Appropriate intravenous lines were subsequently placed. After induction of anesthesia, the patient received antibiotics, Decadron, diuretics, and antiepileptics. Her head was then placed in a Mayfield skull clamp, turned to expose the prior operative area, and registered to the Stealth navigation system. Her prior pterional incision was marked out. The region was then shaved, prepped, and draped in usual sterile fashion. A surgical time-out was performed to confirm the patient's identity and the intended surgical procedure.

Operative Report  
\* Final Report \*

The skin was sharply opened with a 10 blade and monopolar electrocautery was used to carry the dissection down to the skull. This was subsequently reflected forward. The prior craniotomy site was identified and the prior Stryker plating system was removed. The bone flap was then subsequently carefully removed from the prior dural scar and saved. The dural opening was subsequently identified and re-opened. What appeared to be the prior surgical corridor covered with arachnoid and encephalomalacic scar was identified. This was confirmed on the Stealth navigation system as the prior X corridor. With the use of the Stealth navigation system, this prior corridor was re-opened with bipolar forceps and suction. The metastasis was subsequently identified at the floor of the surgical corridor. A combination of bipolar forceps, bipolar electrocautery, and the CUSA was used to fully resect what could be seen of the metastasis. Motors were checked about roughly 80% of how we felt the resection was completed and at that time, the motors were normal as compared to preoperatively. Upon continued resection, there was noted to be significant decrease in motor signals with a decline of roughly 80% to 90%. At this point, it was felt that the surgery had progressed near enough to either the internal capsule or the projections of the motor cortex and so the decision was made to halt resection at that time in case there had been some iatrogenic injury to her motor function. Meticulous hemostasis and irrigation was subsequently achieved. A monolayer of Surgicel was placed within the resection cavity. The dura was then reapproximated with interrupted 4-0 Nurolon and the epidural space was again irrigated and meticulously hemostased. DuraGen was cut to size, laid over the durotomy. The bone was then plated back with a Stryker plating system. The field was again irrigated and meticulous hemostased. The galeal layers were then reapproximated using inverted interrupted 2-0 Vicryl sutures. The skin edges were then reapproximated with 4-0 Monocryl stitch. The incision was dressed with antibiotic ointment. Drapes were then taken down. The patient's head was removed from the Mayfield skull clamp. She was then extubated and taken to the intensive care unit for further monitoring and care. All sponge and needle counts were correct at the end of the procedure. Again, neurophysiologic monitoring using SSEP was stable; however, as noted within the intraoperative report, MEPs were significantly down on the left body, roughly 80% to 90% at the conclusion of the operation.

The patient's condition otherwise at the conclusion of the operation was stable.

Dictated By: Martin Huy Pham

Gene Y Sung, MD

MHP/MODL  
JOB #: 812448/726806122

**Signature Line**

Electronically Signed on 04/13/17 14:20 PDT

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Pham, Martin Huy, MD

Electronically Signed on 02/07/17 06:46 PST

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Sung, Gene Y., MD

Operative Report  
Final Report \*



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F...  
F...  
P...  
P...

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(End of Report)

## Neurosurgery Inpatient Progress Note

\* Final Report \*

**\* Final Report \***

24 hour events: no acute events overnight. POD#1 R crani for resection of R metastatic ovarian cancer (recurrent). LUE and LLE no movement. Pending MRI on 1/7.

**Vital Signs (last 24 hrs)**

<u>Last Charted</u>	<u>Minimum</u>	<u>Maximum</u>
Temp 37 DegC (Axillary) (01/06 18:30)	36.4 DegC (Oral) (01/06 08:08)	37.4 DegC (Axillary) (01/06 16:26)
HRMon 56 (01/07 04:00)	52 (01/06 05:27)	93 (01/06 16:26)
RR 23 (01/07 04:00)	13 (01/07 00:11)	H 29 (01/07 02:12)
SBP 117 (01/07 04:00)	113 (01/07 03:03)	137 (01/06 16:45)
DBP 72 (01/07 04:00)	64 (01/07 03:03)	89 (01/06 19:30)
SpO2 98 (01/07 04:00)	95 (01/06 18:30)	100 (01/06 09:45)

	<u>Recorded</u>	<u>Input</u>	<u>Output</u>	<u>Balance</u>
01/07	07:00-04:44	0	0	0
01/06	7a - 3p	3036.8	2325	711.8
	3p - 11p	731.604	1185	-453.396
	11p - 7a	502.01	675	-172.99
	24hr total	4270.414	4185	85.414

**Labs (Last four charted values)**

WBC	<b>H 11.9</b> (JAN 06)	<b>H 10.2</b> (JAN 06)	H 12.8 (JAN 05)	7.9 (JAN 02)
Hgb	L 11.3 (JAN 06)	13.1 (JAN 06)	13.4 (JAN 05)	13.9 (JAN 02)
Hct	L 33.6 (JAN 06)	38.0 (JAN 06)	39.4 (JAN 05)	40.3 (JAN 02)
Plt	179 (JAN 06)	207 (JAN 06)	219 (JAN 05)	224 (JAN 02)
Na	141 (JAN 06)	142 (JAN 06)	140 (JAN 05)	141 (JAN 02)
K	3.9 (JAN 06)	4.2 (JAN 06)	5.1 (JAN 05)	4.2 (JAN 02)
CO2	22 (JAN 06)	24 (JAN 06)	24 (JAN 05)	27 (JAN 02)
Cl	105 (JAN 06)	103 (JAN 06)	101 (JAN 05)	L 98 (JAN 02)
Cr	L 0.47 (JAN 06)	0.53 (JAN 06)	L 0.49 (JAN 05)	0.51 (JAN 02)
BUN	11 (JAN 06)	18 (JAN 06)	17 (JAN 05)	12 (JAN 02)
Glucose Random	H 223 (JAN 06)	H 148 (JAN 06)	H 185 (JAN 05)	H 147 (JAN 02)
Mg	1.9 (JAN 06)	2.1 (JAN 06)	2.1 (JAN 05)	
Ca	L 8.0 (JAN 06)	9.1 (JAN 06)	9.7 (JAN 05)	9.4 (JAN 02)
PT	H 14.5 (JAN 06)	13.8 (JAN 06)	13.8 (JAN 05)	12.8 (JAN 02)
INR	H 1.14 (JAN 06)	1.07 (JAN 06)	1.07 (JAN 05)	0.97 (JAN 02)

**Medications (19) Active**

Scheduled: (6)

dexamethasone 4 mg/mL INJ 1 mL 6 mg 1.5 mL, IV Push, Q6H

docusate sodium 100 mg Cap 100 mg 1 caps, Oral, BID

famotidine 20 mg Tab 20 mg 1 tabs, Oral, Q12H

insulin regular 100 units/mL INJ 10 mL MODERATE CORRECTIONAL DOSE, Subcutaneous, ACHS

levETIRAcetam Premix 1,000 mg 100 mL, IVPB, Q12H

senna 8.6 mg Tab 8.6 mg 1 tabs, Oral, Nightly

Continuous: (1)

Sodium Chloride 0.9% 1,000 mL 1,000 mL, IV Continuous, 100 mL/hr

PRN: (12)

acetaminophen 325 mg Tab 650 mg 2 tabs, Oral, Q6H-INT

acetaminophen 325 mg Tab 650 mg 2 tabs, Oral, Q6H-INT

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acetaminophen-HYDROcodone 325 mg-10 mg Tab 1 tabs, Oral, Q6H-INT  
acetaminophen-HYDROcodone 325 mg-5 mg Tab 1 tabs, Oral, Q6H-INT  
dextrose 50% INJ Syringe 50 mL 25 mL, IV Push, Q15MIN-INT  
dextrose 50% INJ Syringe 50 mL 50 mL, IV Push, Q15MIN-INT  
glucagon 1 mg INJ PWVL 1 mg, Intramuscular, Q15MIN-INT  
hydrALAZINE 20 mg/mL INJ 1 mL 10 mg 0.5 mL, IV Push, Q10MIN-INT  
labetalol 5 mg/mL INJ Syringe 4 mL 10 mg 2 mL, IV Push, Q10MIN-INT  
morphine 4 mg/1 mL INJ Syringe 2 mg 0.5 mL, IV Push, Q2H-INT  
ondansetron 2 mg/mL INJ 2 mL 4 mg 2 mL, IV Push, Q6H-INT  
senna 8.6 mg Tab 17.2 mg 2 tabs, Oral, ONCE

**Physical exam:**

E4M6V5, c/o of moderate pain

A&Ox4, NAD, sleeping in bed comfortably, breathing room air.

EOMI, PERRL

**LUE and LLE no movement**

RUE and LLE moves to commands

Wound c/d/i

**MRI Brain STEALTH w/ and w/o 1/4/17**

Interval increase in size of a heterogeneously enhancing, partially calcified metastatic lesion within the right lentiform region, as detailed above, likely consistent with disease progression.

There is interval increase in perilesional vasogenic edema, with resultant increased right-to-left midline shift of 12 mm, previously 9 mm, and interval increase in perilesional diffusion restriction, which may reflect tumor cellularity with/without an element of ischemia.

**Assessment/Plan**

A/P: 59yo F w/ recurrent metastatic OV CA w/ known brain mets who presented 1/3/17 w/ lethargy, progressive left sided weakness and HA found to have interval increase in right lentiform region mass (likely met) w/ associated increased vasogenic edema extending into right frontal, parietal, and temporal lobes, and with minimal new extension into the pons. S/p R crani for resection 1/6.

Neuro

# Vasogenic Cerebral Edema, c/b increasing midline shift

- Midline shift increased, previously 9mm, now 12mm.

- Presenting sx of HA/lethargy/N/V likely 2/2 dz progression (R lentiform region met) w/ associated increased vasogenic edema

- Symptoms/exam improved s/p Dexamethasone.

- **6mg Q6h IV Dexamethasone**; recommend in 4days to decrease to 6mg TID; post operative, neurosurg to define dexamethasone taper.

- q4 neurochecks. Keppra 1g Q12H.

- Norco Q6H prn pain. Morphine 2mg Q2H breakthrough

- PT/OT once appropriate

# CV

- EKG NSR

- SBP <140, hydralazine pm >140SBP.

FENGI/PPX

- F: NS 100ml/hr.--> taper off when tolerating diet

- E: replete PRN; Na goal 140-145

- N: passed bedside swallow; consistent carbohydrate diet.

- GI: PPI, bowel regimen

- PPX: SCD

ENDO:

REVIEWED: 9/20/2021  
FAXED: 9/20/2021

Page 2 of 4  
(Continued)

*urosurgery Inpatient Progress Note*  
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•ISS while on dexa

ONC

- recurrent metastatic IIC (FIGO 3) Papillary Serous OV CA
- Plan to transfer to GYN ONC primary service (appreciate transfer) once on the floor

#DISPO: pending transfer back to GYN-Onc after stabilization of neurological status.

Martinez Monedero

Lee

Chang

DWA Dr. Pham

Admitted from emergency room [ ] Transfer from acute center [ ] transfer from skilled nursing facility / long term acute care facility [ ]

Palliative Care [ ] Ventilator within 24h of Admission [x]

Neurologic: Coma [ ] Coma > 24h [ ] Loss of consciousness <30 m[ ] 30m-1h [ ] 1-6h [ ] 6-24h [ ] >24h [x] Without return to pre-injury level [x]

*Dementia [ ] Delirium [ ] Encephalopathy [x] Compression of brain [x] Cerebral Edema [x] Anoxic brain damage [ ] Locked in*

*Dementia [ ] Delirium [ ] Encephalopathy [x] Compression of brain [x] Cerebral Edema [x] Anoxic brain damage [ ] Locked in*

State [ ] PRES [ ]

Concussion [ ] loss of consciousness <30 m[ ] 30m-1h [ ] 1-6h [ ] 6-24h [ ] >24h [x]

Diffuse Traumatic Brain Injury [ ] loss of consciousness <30 m[ ] 30m-1h [ ] 1-6h [ ] 6-24h [ ] >24h [ ]

Skull fracture [ ] of \_\_\_\_\_, displaced [ ] open [ ]

Communicating Hydrocephalus [ ] Noncommunicating hydrocephalus [ ] Cerebrospinal fluid leak [ ]

Cerebral infarction [ ] due to embolism [ ] stenosis [ ] thrombosis [ ] cerebral venous thrombosis [ ] other [ ] \_\_\_\_\_

Dissection: cerebral artery [ ] carotid [ ] vertebral [ ] other [ ] \_\_\_\_\_

Subarachnoid hemorrhage [ ] traumatic [ ] due to \_\_\_\_\_ acute [ ] subacute [ ] chronic [ ] loss of consciousness <30 m[ ] 30m-1h [ ] 1-6h [ ] 6-24h [ ] >24h [ ]

Intracerebral hemorrhage/contusion [x] traumatic [ ] due to \_\_\_\_\_ located in cerebellum acute [ ] subacute [x] chronic [ ] loss of consciousness <30 m[ ] 30m-1h [ ] 1-6h [ ] 6-24h [ ] >24h [x]

Intraventricular hemorrhage [ ] traumatic [ ]

Subdural hemorrhage [ ] traumatic [ ] acute [ ] subacute [ ] chronic [ ] loss of consciousness <30 m[ ] 30m-1h [ ] 1-6h [ ] 6-24h [ ] >24h [ ]

Epidural hemorrhage [ ] traumatic [ ] acute [ ] subacute [ ] chronic [ ] loss of consciousness <30 m[ ] 30m-1h [ ] 1-6h [ ] 6-24h [ ] >24h [ ]

Malignant primary neoplasm of brain [ ] of \_\_\_\_\_ type in \_\_\_\_\_ location, **Metastatic cancer / malignant secondary neoplasm to brain [x] of Ovarian cancer type in \_\_\_\_\_ location**

Malignant primary neoplasm of spinal cord [ ] of \_\_\_\_\_ type in \_\_\_\_\_ location, Metastatic cancer / malignant secondary neoplasm to spinal cord [ ] of \_\_\_\_\_ type in \_\_\_\_\_ location

Benign neoplasm [ ] of \_\_\_\_\_ type in \_\_\_\_\_ location

Epilepsy [ ] intractable [ ] status epilepticus [ ]

Spinal fracture [ ] of \_\_\_\_\_ level of \_\_\_\_\_ type acute [ ] subacute [ ] chronic [ ] displaced [ ] unstable [ ]

Spinal Cord Compression [ ] Cauda Equina Syndrome [ ] Quadriplegia [ ] Acute Spinal cord infarction [ ] Anterior cord syndrome [ ] at \_\_\_\_\_ level, Central cord syndrome [ ] at \_\_\_\_\_ level, Complete spinal cord injury [ ] at \_\_\_\_\_ level, Incomplete spinal cord injury [ ] at \_\_\_\_\_ level

OTHER DIAGNOSES: \_\_\_\_\_

Psychiatric: Abuse [ ] of \_\_\_\_\_ Dependence [ ] on \_\_\_\_\_ Withdrawal [ ] from \_\_\_\_\_

OTHER DIAGNOSES: \_\_\_\_\_

Cardiovascular: Hypotension [ ] Shock [ ] of \_\_\_\_\_ etiology, Arrhythmia [ ] of \_\_\_\_\_ type STEMI [ ] NSTEMI [ ] Acute Endocarditis [ ] Acute Myocarditis [ ] Cardiac Arrest [ ] Acute Systolic Heart Failure [ ] Acute Diastolic Heart Failure [ ] Chronic Systolic Heart Failure [ ] Chronic Diastolic Heart Failure [ ]

OTHER DIAGNOSES: \_\_\_\_\_

Pulmonary: Acute Respiratory failure [x] Acidosis [ ] Hypoxemia [ ] Hypercapnia [ ] Pulmonary embolism [ ] Saddle pulmonary embolism [ ] Pulmonary heart disease [ ] COPD [ ] Asthma [ ] Bronchitis [ ] Pneumonia [ ] with Aspiration [ ] of \_\_\_\_\_ type

OTHER DIAGNOSES: \_\_\_\_\_

Gastrointestinal/Nutritional/ Electrolyte: Malnutrition [ ] Liver disease [ ] acute [ ] of \_\_\_\_\_ type Hyponatremia [ ] Hypernatremia [ ]

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Hypokalemia [ ] Hyperkalemia [ ] Hypocalcemia [ ] Hypercalcemia [ ] Hypomagnesemia [ ] Hypermagnesemia [ ] OTHER

DIAGNOSES: \_\_\_\_\_

Genitourinary: Chronic Kidney Disease 4 [ ] Chronic Kidney Disease 5 [ ], Acute Kidney Failure [ ], hemodialysis [ ]

OTHER DIAGNOSES: \_\_\_\_\_

Hematologic: Acute post hemorrhagic anemia [ ], Acute anemia [ ] due to \_\_\_\_\_, Chronic anemia [ x] due to \_\_\_\_\_, Disseminated Intravascular Coagulation [ ] Lymphoma [ ] of \_\_\_\_\_ type located in \_\_\_\_\_, Leukemia[ ] of \_\_\_\_\_ type, in remission [ ] in relapse [ ]

OTHER DIAGNOSES: \_\_\_\_\_

Infectious/ Inflammatory SIRS [ ] Sepsis [ x] due to \_\_\_\_\_, with Septic shock[ ], Abscess [ ] due to klebsiella organism in BAL, blood location, Meningitis [ ] due to \_\_\_\_\_ organism Encephalitis [ ] due to \_\_\_\_\_ organism , ventriculitis [ ] due to \_\_\_\_\_

OTHER DIAGNOSES: \_\_\_\_\_

Endocrinology: Type 1 Diabetes Mellitus [ ] Type 2 Diabetes Mellitus [ x] with Ketoacidosis [ ] with Coma [ ] with hyperosmolarity [ ] Hypopituitarism [ ] Hypothyroidism [ ] Adrenocortical insufficiency [ ] Cushing Syndrome [ ] Cushing Disease [ ] Diabetes Insipidus [ ]

OTHER DIAGNOSES: \_\_\_\_\_

Integumentary / Musculoskeletal: Pressure ulcer [ ] stage \_\_\_, Fracture [ ] of \_\_\_, displaced [ ] open [ ]

**Signature Line**

Electronically Signed on 06/12/17 12:00 PDT

Martinez Monedero, Rodrigo, MD

Electronically Signed on 01/07/17 08:06 PST

Chang, Ki-Eun, MD

Electronically Signed on 01/21/17 10:16 PST

Pham, Martin Huy, MD

Lee, Justin C., MD



in OR Intraoperative Record  
nal Report \*



### \* Final Report \*

#### >Main OR Intraop Nursing Record (Verified)

##### SC Main OR Intraop Nursing Record Summary

Primary Physician: Pham, Martin Huy  
use Number: USCOR-2017-126  
alized Date/Time: 01/06/17 16:40:04  
Name: [REDACTED]  
O.B./Sex: [REDACTED]  
d Rec #: 100146405  
ysician: ERADMADT, ERADMADT  
nancial #: 1006373034  
Type: I  
om/Sed: OR/05  
mit/Disch: 01/02/17 22:25:00 -  
stitution:

##### safety Checklist 2) Time Out - USC MOR

###### Post-Care Text:

A.10 Confirms patient identity A.20 Verifies operative procedure, surgical site, and laterality A.20.1 Verifies consent for planned procedure A.30 Verifies allergies

###### Entry 1

Final Time Out was conducted based on the DHS Final Time Out	Yes	Comments	N/A
Checklist/Standards: All Time Out participants ceased activity, confirmed patient, site, procedure, and consents	Yes	Comments	N/A
Time Out Members	Chang, Ki-Eun, Selzer, Sydney R, Chavezticas RN, David, POORMAN, CHELSEA, Sam, John, Vesely, Michael	Time Out Time	01/06/17 11:59:00

###### Post-Care Text:

E.30 Evaluates verification process for correct patient, site, side, and level surgery

##### Surgical Procedures - USC MOR

###### Post-Care Text:

A.20 Verifies operative procedure, surgical site, and laterality A.20.2 Assesses the risk for unintended retained foreign body Im.20 Performs required counts

###### Entry 1

Procedure Description	Procedure	Procedure Code	
	Craniotomy Tumor Resection Image-Guided		Craniectomy, trephination, bone flap craniotomy; for excision of brain abscess, supratentorial
Modifiers	Right		

ited by:

ited on:



in OR Intraoperative Record  
Final Report \*

Primary Procedure	Yes	Attending Surgeon of Record	Pham, Martin Huy
Start	01/06/17 12:00:00	Stop	01/06/17 15:51:00
Anesthesia Type	General	Surgical Service	Neurosurgery (SN)
Fluid Class	1-Clean		

**Post-Care Text:**

O.730 The patient's care is consistent with the individualized perioperative plan of care

**Case Times - USC MOR**

**Entry 1**

Patient		Patient Out Room	
Patient In Room Time	01/06/17 09:35:00	Time	01/06/17 16:24:00
Use		Procedure Stop Time	
Procedure Start Time	01/06/17 12:00:00		01/06/17 15:51:00

**Case Attendance - USC MOR**

**Entry 1**

Use Attendee	Pham, Martin Huy	Entry 2	
Role Performed	Surgeon - Attending		
me In	01/06/17 09:35:00		
me Out	01/06/17 16:24:00		
Procedure(s)	Craniotomy Tumor		
	Resection		
	Image-Guided(Right)		

**Entry 4**

Use Attendee	Chaveztticas RN, David	Entry 5	
Role Performed	Scrub - Primary		
me In	01/06/17 09:35:00		
me Out	01/06/17 16:24:00		
Procedure(s)	Craniotomy Tumor		
	Resection		
	Image-Guided(Right)		

**Entry 7**

Use Attendee	Vesely, Michael	Entry 8	
Role Performed	Other Authorized		
Personnel			
me In	01/06/17 09:35:00		
me Out	01/06/17 16:24:00		
Procedure(s)	Craniotomy Tumor		
	Resection		
	Image-Guided(Right)		

**Entry 10**

Use Attendee	Alexander, Russel	Entry 9	
Role Performed	Anesthesiologist -		
Attending			
me In	01/06/17 14:51:00		
me Out	01/06/17 16:30:00		
Procedure(s)	Craniotomy Tumor		
	Resection		
	Image-Guided(Right)		

ited by:  
ited on:

Page 2 of 9  
(Continued)

in OR Intraoperative Record  
nal Report \*

**atheter, Drains, Tub - USC MOR**

**e-Care Text:**

A.310 Identifies factors associated with an increased risk for hemorrhage or fluid and electrolyte imbalance  
Im.250 Administers care to invasive device sites

**Entry 1**

vice Description	TRAY CATHETERIZATION SURESTEP BARDEX COMPLETE CARE STATLOCK 16FR URINE METER	Device Type	Indwelling
ication	Bladder	Balloon Inflation Amount	10mL
esent on Arrival?	No	Inserted By	Sam, John
at End of Case?	No		
ainage Details			
rainage?	Yes	Amount	Measured in Milliliters (mL)
olor	Yellow	Consistency	Watery
rainage System	Dependent drainage bag		
itcome Met (0.60)	Yes		

**e-Care Text:**

E.340 Evaluates tubes and drains are intact and functioning as planned 0.60 Patient is free from signs and symptoms of injury caused by extraneous objects

**ounts Verification - USC MOR**

**e-Care Text:**

A.20 Verifies operative procedure, surgical site, and laterality A.20.2 Assesses the risk for unintended retained foreign body Im.20 Performs required counts

**Entry 1**

rocedure	Craniotomy Tumor Resection Image-Guided(Right)	Items included in the Initial Count	Sponges, Sharps
initial Counts			
initial Counts	Chavezicas RN, David, Sam, John	Items included in the Initial Count	Sponges, Sharps
erformed By			
ivity Count			
osing Counts			
losing Counts	Chavezicas RN, David, Sam, John	Items included in the Closing Count	Sponges, Sharps
erformed By			
nal Counts			
inal Count Status	Correct	Did you use Radio Frequency Wanding for this case?	No
inal Counts		Items Included in Final Count	Sponges, Sharps
erformed By			
itcome Met (0.20)	Relente, Dioscoro, Chavezicas RN, David Yes		

**e-Care Text:**

E.50 Evaluates results of the surgical count 0.20 Patient is free from unintended retained foreign objects

**ounts Ver Additional - USC MOR**

**e-Care Text:**

A.20 Verifies operative procedure, surgical site, and laterality A.20.2 Assesses the risk for unintended retained foreign body Im.20 Performs required counts

**Entry 1**

ditional Count	Shift Change	Additional Count Participants	Relente, Dioscoro
pe		Items Counted	Sponges, Sharps
unt Status	Correct		
itcome Met (0.20)	Yes		

**e-Care Text:**

E.50 Evaluates results of the surgical count 0.20 Patient is free from unintended retained foreign objects

ited on [REDACTED]

in OR Intraoperative Record  
nal Report \***Patient Positioning - USC MOR****Pre-Care Text:**

A.240 Assesses baseline skin condition A.280 Identifies baseline musculoskeletal status A.280.1 Identifies physical alterations that require additional precautions for procedure-specific positioning A.510.8 Maintains patient's dignity and privacy Im.120 Implements protective measures to prevent skin/tissue injury due to mechanical sources Im.40 Positions the patient Im.80 Applies safety devices

**Entry 1**

<b>Procedure</b>	Craniotomy Tumor Resection	<b>Body Position</b>	Supine
<b>Right Arm Position</b>	Image-Guided(Right) Tucked and padded at side	<b>Right Arm Position</b>	Tucked and padded at side
<b>Right Leg Position</b>	Elevated	<b>Right Leg Position</b>	Elevated
<b>Net Uncrossed?</b>	Yes	<b>Pressure Points Checked</b>	Yes
<b>Positioning Device</b>	Board - Arm, Elbow Protector, Head Protector, Strap - Safety, Table - Standard	<b>Positioned By</b>	Chang, Ki-Eun, Selzer, Sydney R, Chavezticas RN, David, Sam, John
<b>Safety Strap Applied?</b>	Yes	<b>Location</b>	Above Knees, Abdomen
<b>Outcome Met (0.80)</b>	Yes		

**Post-Care Text:**

E.10 Evaluates for signs and symptoms of physical injury to skin and tissue E.290 Evaluates musculoskeletal status O.80 Patient is free from signs and symptoms of injury related to positioning

**Assessment of Body - USC MOR****Entry 1**

<b>Date/Time Checked</b>	01/06/17 12:40:00	<b>Site</b>	Arm, left, Arm, right, Torso, Leg, left, Leg, right
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**General Comments:**

BUE AND BLE WARM TO TOUCH WITH PULSES PAPABLE. RRECT POSITION AND AGLINMENT. HEAD SECURED IN STERILE FIELD WITH MAYFIELD.

**Skin Prep - USC MOR****Pre-Care Text:**

A.30 Verifies allergies A.20 Verifies procedure, surgical site, and laterality A.510.8 Maintains patient's dignity and privacy Im.270 Performs Skin Preparation Im.270.1 Implements protective measures to prevent skin and tissue injury due to chemical sources A.300.1 Protects from cross-contamination

**Entry 1**

<b>Skin Prep</b>		<b>Prep By</b>	Chavezticas RN, David
<b>Prep Agents (Im.270)</b>	Iodine Povacrylex and Isopropyl Alcohol	<b>Prep Area Details</b>	
<b>Prep Area (Im.270)</b>	Head		Right
<b>Skin Prep Agent Dry</b>	Yes		
<b>Without Pooling</b>			
<b>Hair Removal</b>			
<b>Hair Removal Methods</b>	Clipper	<b>Hair Removal By</b>	Chang, Ki-Eun
<b>Hair Removal Site</b>	Head	<b>Hair Removal Site Details</b>	Right
<b>Outcome Met (0.100)</b>	Yes		

**Post-Care Text:**

E.10 Evaluates for signs and symptoms of physical injury to skin and tissue O.100 Patient is free from signs and symptoms of chemical injury

**General Case Data - USC MOR****Pre-Care Text:**

A.350.1 Classifies surgical wound

in OR Intraoperative Record  
nal Report \*

**Entry 1**

<b>use Information</b>		<b>Case Level</b>	
IR	USC OR 07	Specialty	5
ound Class	1-Clean		Neurosurgery (SN)
SA Class	3		
epo Diagnosis	Malignant neoplasm of brain		

**st-Care Text:**

O.760 Patient receives consistent and comparable care regardless of the setting

**plant Log - USC MOR**

**e-Care Text:**

A.20 Verifies operative procedure, surgical site, and laterality A.20.1 Verifies consent for planned procedure  
Im.350 Records implants inserted during the operative or invasive procedure

<b>Entry 1</b>	<b>Entry 2</b>	<b>Entry 3</b>
----------------	----------------	----------------

<b>plant/Explant</b>	Implant	Implant	Implant
<b>plant</b>			
<b>entification</b>			
<b>escription</b>	GRAFT SOFT TISSUE DURAFORM COLLAGEN L3 IN X W3 IN DURAL TEXTURE TOP SURFACE SMOOTH BOTTOM STERILE	53-05514 14MM BURR HOLE C	PLATE BONE 12MM CRANIOMAXILLOFACIAL TITANIUM 2 HOLE LOW PROFILE BAR 1.5MM SCREW
<b>ize</b>	3X3	14MM	12MM
<b>erial Number</b>	CT004102	CT004102	CT004102
<b>ot Number</b>	CODMAN	STRYKER	STRYKER
<b>anufacturer</b>		CRANIOMAXILLOFACIAL	
<b>atalog #</b>	801478	53-055514	5305212
<b>xpiration Date</b>	10/31/18	10/31/18	
<b>age Data</b>			
<b>plant Site</b>	Scalp	Scalp	Scalp
<b>uantity</b>	1	3	1
<b>itcome Met (0.30)</b>	Yes	Yes	Yes

**Entry 4**

<b>plant/Explant</b>	Implant
<b>plant</b>	
<b>entification</b>	
<b>escription</b>	SCREW BONE LEIBINGER TITANIUM L4 MM OD1.5 MM NEURO SELF TAP CROSS PIN NONSTERILE
<b>ize</b>	4MM
<b>erial Number</b>	CT004102
<b>ot Number</b>	STRYKER
<b>anufacturer</b>	
<b>atalog #</b>	5015004
<b>xpiration Date</b>	
<b>age Data</b>	
<b>plant Site</b>	Scalp
<b>uantity</b>	14
<b>itcome Met (0.30)</b>	Yes

**st-Care Text:**

E.30 Evaluates verification process for correct patient, site, side and level surgery O.30 Patient's procedure  
is performed on the correct site, side, and level

**edication Administration - USC MOR**

**e-Care Text:**

E.10 Evaluates for signs and symptoms of physical injury to skin and tissue O.10 Patient is free from

in OR Intraoperative Record  
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	Entry 1	Entry 2	Entry 3
Med Administered			
Medication	BACITRACIN 50,000 UNITS/1 VIAL INJECTION	LIDOCAINE 1% with EPINEPHRINE 1:100,000 INJ, 20 ML INJ	THROMBIN TOPICAL 20,000 UNITS
Route of Admin	Topical	Subcutaneous	Topical
use			
Volume	100000 units	8 mL	40000 units
Administered By	Chang, Ki-Eun	Chang, Ki-Eun	Chang, Ki-Eun
Outcome Met (0.130)	Yes	Yes	Yes

**Post-Care Text:**

E.20 Evaluates response to medications 0.130 Patient receives appropriately administered medication(s)

**Patient Care Devices - USC MOR**

**Pre-Care Text:**

A.200 Assesses risk for normothermia regulation A.40 Verifies presence of prosthetics or corrective devices  
Im.280 Implements thermoregulation measures Im.60 Uses supplies and equipment within safe parameters

	Entry 1	Entry 2	Entry 3
Equipment Type	WARMER BAIR HUGGER *USC	PUMP, ALP 501 COMPRESSION *USC 28743 BLE	TABLE CMAX *USC
Serial Number	48141		C431107089
Settings (if applicable)	43 LOWER		
Adv Number (if applicable)			
Item Sterilized			
Comments			
Outcome Met (0.700)	Yes	Yes	Yes

	Entry 4	Entry 5	Entry 6
Equipment Type	MICROSCOPE PENTERO *USC	NAVIGATION MACHINE WITH MONITOR *USC	C-USA - INTEGRA *USC
Serial Number	6631420991		HFB14027021E
Settings (if applicable)			
Adv Number (if applicable)			
Item Sterilized			
Comments			
Outcome Met (0.700)	Yes	Yes	Yes

**Post-Care Text:**

E.10 Evaluates signs and symptoms of physical injury to skin and tissue 0.700 Patient is free from signs and symptoms of injury caused by extraneous objects

**Surgical Irrigation - USC MOR**

**Pre-Care Text:**

A.280 Verifies allergies A.310 Identifies factors associated with an increased risk for hemorrhage or fluid and electrolyte imbalance Im.210 Administers prescribed solutions A.280.1 Implements protective measures to prevent skin or tissue injury due to thermal sources

	Entry 1	Entry 2
Irrigant	Yes	Yes
Irrigant Used:	SOLUTION INTRAVENOUS VIAFLEX LACTATED RINGERS 1 L LATEX FREE	SOLUTION IRRIGATION WATER 1 L PLASTIC POUR BOTTLE STERILE
Irrigant Volume In	1 L	1 L
Irrigant Volume Out	1 L	1 L
1. Irrigation		
2. Additives must be		
3. Administered in the Med		

in OR Intraoperative Record  
nal Report \*

ministration  
gment.  
tcome Met (0.300) Yes Yes

**Post-Care Text:**

E.10 Evaluates for signs and symptoms of physical injury to skin and tissue 0.300 Patient is free from signs and symptoms of injury due to thermal sources

**Autery - USC MOR**

**e-Care Text:**

A.240 Assesses baseline skin condition A280.1 Identifies baseline musculoskeletal status Im.50 Implements protective measures to prevent injury due to electrical sources Im.60 Uses supplies and equipment within safe parameters Im.80 Applies safety devices

	Entry 1	Entry 2
EU Type	Bipolar Unit	Electrosurgical Unit
Identification Number	102813	f1f18042a
Accessories Used		
EU Settings		
Bipolar Setting	45	
Blend Setting		45
Coag Setting		45
Cut Setting		45
Instrument/Model Type		
Other Settings		
Percentage		
Power Level		
Temperature (Celsius)		
Total Time Used		
Grounding Pad Details		
Grounding Pad Needed?	No	Yes
Grounding Pad Lot Number		62080269X EXP 2018-08
Within Expiration Date?		Yes
Grounding Pad Site		Thigh
Grounding Pad Site Detail		Right
Hair Removed Under Grounding Pad		No
Hair Removed Using:		
Skin Condition Under Grounding Pad		Intact
Verified By		Sam, John
Wake Evacuation Device Used	No	No
Wake Evacuation Unit:		
Outcome Met (0.10)	Yes	Yes

**Post-Care Text:**

E.10 Evaluates for signs and symptoms of physical injury to skin and tissue 0.10 Patient is free from signs and symptoms of injury related to thermal sources

**Cultures and Specimen - USC MOR**

**e-Care Text:**

A.20 Verifies operative procedure, surgical site, and laterality Im.320 Manages culture specimen collection Im.330 Manages specimen handling and disposition

Entry 1	Entry 2
Cultures Ordered	n/a

Specimens Ordered Yes

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Outcome Met (0.40) Yes

**Post-Care Text:**

E.40 Evaluates correct processes have been performed for specimen handling and disposition 0.40 Patient's specimen(s) is managed in the appropriate manner

**General Comments:**

Chang, Ki frozen 1. right brain met routine 1. IN FORMALIN 1. right brain met routine

**Washing/Packing - USC MOR**

**Pre-Care Text:**

A.350 Assesses susceptibility for infection Im.250 Administers care to invasive devices Im.290 Administer care to wound sites Im.300 Implements aseptic technique

**Entry 1**

Wash Prep Agent Yes

Moved Prior to

Washing?

Washing Item

Details

Washing Item Other: See comments

(Im.290)

Site Head

Outcome Met (0.200) Yes

**Site Details**

Right

**Post-Care Text:**

E.320 Evaluate factors associated with increased risk for postoperative infection at the completion of the procedure 0.200 Patient's wound perfusion is consistent with or improved from baseline levels

**General Comments:**

Non-adhesive Telfa Dressing

**Communication - USC MOR**

**Entry 1**

**Entry 2**

Communication Patient Flow/Bed Control

Communication By Relente, Dioscoro

Date and Time 01/06/17 15:40:00

RN Report to Unit/Floor

Relente, Dioscoro

01/06/17 16:15:00

**Skin Assessment - USC MOR**

**Pre-Care Text:**

A.240 Assesses baseline skin condition Im.120 Implements protective measures to prevent skin or tissue injury due to mechanical sources Im.280.1 Implements protective measures to prevent skin or tissue injury due to thermal sources Im.360 Monitors for signs and symptoms of infection

**Entry 1**

Skin Integrity Intact

Outcome Met (0.60)

Yes

**Post-Care Text:**

E.10 Evaluates for signs and symptoms of physical injury to skin and tissue E.270 Evaluate tissue perfusion 0.60 Patient is free from signs and symptoms of injury caused by extraneous objects

**Safety Checklist 3) Sign Out - USC MOR**

**Pre-Care Text:**

Im.330 Manages specimen handling and disposition

**Entry 1**

Nurse verbally

Confirms with team

The name of the

operative

Procedure(s) and

Correct CPT code

Nurse verbally

Confirms with team

Any equipment

Problems to be

Nurse verbally

Confirms with team

Specimen identity

and label

Yes

The nurse confirmed

with the surgeon

and the incision is:

Closed

[REDACTED]

[REDACTED]

[REDACTED]

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Dressed	Yes	All team members review key concerns for recovery and management of patient	Yes
Are the instrument, sponge, and needle counts correct?		Was this an endoscopic case?	No
Is this case a trauma case?	No		
Is an implant used for this case?	Yes		
<b>Post-Care Text:</b> E.800 Ensures continuity of care E.50 Evaluates results of the surgical count			
<b>General Comments:</b> PROCEDURE AND CPT CODE VERIFIED WITH DR. KI-RUN CHANG.			
<b>Departure from OR - USC MOR</b> Entry 1			
Transport Time	01/06/17 16:25:00	Patient Handoff Status	Drowsy
Transfer Evaluation Reassessment	ESU Pad Site Checked, Tubes Drains Chains Secured, Warm Blanket Applied, Pressure Areas Checked, Sterile Dressing Intact Extubated	Skin Condition	Warm, Dry
Patient Handoff Status	6 L/min	Oxygen in Use?	Yes
Patient IV Access	Yes	Airway Device Post-op Destination	Nasal Cannulae or Mask PACU
Patient	Gurney	Report Given To	PANYAPITAK, SUPALAK
Discharge Report Given By	Relente, Dioscoro		
Time	01/06/17 16:28:00		
Discharged/Transferred			

**Case Comments**

&lt;None&gt;

Finalized By: Relente, Dioscoro

**Document Signatures****Signed By:**

Relente, Dioscoro 01/06/17 16:40